UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
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UNITED STATES OF AMERICA,

v. 10 CR 553 (SHS)

MONDHER BEJAOUI,

Defendant.

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New York, N.Y.
August 13, 2012
10:15 a.m.

Before:

HON. SIDNEY H. STEIN,

District Judge

APPEARANCES

PREET BHARARA
United States Attorney for the
Southern District of New York
ALEXANDER WILSON
RACHEL KOVNER
Assistant United States Attorney

JOSHUA L. DRATEL
Attorney for Defendant Bejaoui

(Case called)

MS. KOVNER: Good morning, your Honor.

Rachel Kovner and Alex Wilson, for the government and we're joined by a paralegal.

THE COURT: Good morning.

MR. DRATEL: Joshua Dratel and Mr. Bejaoui is seated.

THE COURT: All right. Good morning. Please be seated.

Move the computer monitor away from Mr. Bejaoui's face so I could see him.

All right. Thank you. This is a hearing to determine whether Mr. Bejaoui is competent to proceed pursuant to 18 U.S.C. 4247(D). The defendant has moved for a hearing to determine the competency of the defendant. And the question is whether or not the defendant may presently, whether or not the defendant is presently suffering of the mental disease or defect rendering him mentally incompetent to the extent that he is unable to determine, unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense.

Mr. Dratel, do you agree that's the issue before the Court?

MR. DRATEL: Correct, your Honor.

THE COURT: Government?

MS. KOVNER: Yes.

THE COURT: All right. Who are the witnesses for the government?

MS. KOVNER: Your Honor, the government anticipates calling one witness and that's Dr. Robert Cochrane. We've discussed with Mr. Dratel the order of the witnesses and it's our expectation because it's the defendant's burden in this case that the first defense witness will be testifying first.

THE COURT: All right. Mr. Dratel, who are the defense witnesses?

MR. DRATEL: Dr. Michael First and Jean Barrett.

THE COURT: I've received the faxed letter of the government dated August 10 and faxed at 13 minutes before midnight on August 11.

Mr. Dratel, how long do you think the direct-examination of Dr. First is going to be?

MR. DRATEL: My guess would be an hour, maybe a little longer, maybe a little less.

THE COURT: I am not holding you to it. I am just trying to get the sense. And of Ms. Barrett?

MR. DRATEL: Probably 15 minutes is my guess.

THE COURT: All right. And, government, how long do you think the direct of Dr. Cochrane is going to be?

MR. WILSON: Probably about an hour and a half, your Honor.

THE COURT: All right. Now, I want both Dr. First and

Dr. Cochrane in the courtroom now.

MR. DRATEL: They are, your Honor.

THE COURT: I'd appreciate it if both of them stay throughout this proceeding. I want each to hear the testimony of the other.

MR. DRATEL: We've agreed on that, your Honor, the government and the defense as well.

THE COURT: All right. And the parties themselves have agreed that it's the defense that has the burden here?

MR. DRATEL: Yes, your Honor. I couldn't really find anything to the contrary in that regard. So we do have a burden of establishing his competency.

THE COURT: Well, you have the burden to establish incompetency. Is that what you said?

MR. DRATEL: Well, I think it's our motion that he is not competent.

THE COURT: All right. I am informed that the Supreme Court agrees with you Cooper v. Oklahoma. I'll take a look at it because I am not, particularly, familiar with that case but everyone agrees that defense has the burden on this motion and the motion is that to prove by a preponderance that he suffers from a mental disease or defect rendering him mentally incompetent to the extent he is unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense. We are all agreed.

All right. Put your first witness on please.

MR. DRATEL: Your Honor, just one issue. I guess we can do it at the time Ms. Barrett comes to discuss --

THE COURT: You are talking about the attorney/client issue?

MR. DRATEL: Yes.

THE COURT: All right. We'll wait.

DR. MICHAEL B. FIRST,

called as a witness by the Defendant,

having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. DRATEL:

Q. Dr. First, could you tell us what you do professionally?

A. I am a psychiatrist. I am a professor of clinical psychiatry at Columbia University. I am also employed as a research psychiatrist at the New York State Psychiatric institute. I also maintain a private practice in Manhattan.

Q. And how long have you been practicing?

A. I have been practicing -- I finished my residency in 1987 and I have been practicing since then. So a little shy of 30 years.

Q. And have you regularly had a hospital position during the course of your practice?

A. Yes. I have an appointment at Presbyterian Hospital which is connected to Columbia University Medical Center.

Q. Do you remember when that began?
A. I started with my residency and now I am an attending but it began as a resident and it continued all the way through. It's also the same period of time.
Q. Have you been involved in psychiatric diagnoses in the context of any kind of --
MR. DRATEL: Your Honor, may I lead a little in this context?
THE COURT: The answer to that is it depends. Let's hear the question.
Q. Are you involved in editing any manuals?
A. Yeah. Let me clarify. My entire research career since I finished my residency was in the area of psychiatric diagnosis and assessment.
THE COURT: And assessment?
A. The manual that is used for diagnosing mental disorders in the United States and around the world is called the DSM, the Diagnostic and Statistical Manual. And a manual was developed at Columbia University by my mentor, Robert Spitzer. So I specifically came to Columbia to work on that manual when I finished my residency in 1987 and I have been working on issues of diagnosis and assessment as my main research area ever sense. And as part of that I am also the lead author of an instrument called the SCID, S-C-I-D, which is the structured clinical interview for DSM diagnoses which is the most widely

used clinical instrument and research instrument for making a research diagnosis in the United States and around the world. And in the context of that I've done training on how to do psychiatric diagnosis to thousands of clinicians and researchers. So it has been my area of research and expertise for, basically, the past 30 years.

THE COURT: Now, you said you developed a SCID, is that correct?

THE WITNESS: That's correct.

THE COURT: That is an instrument to diagnose people psychiatrically?

THE WITNESS: Right. It's used -- it's a structured interview. So it has specific questions which have been developed to guide the user to make, to apply to the criteria in the DSM manual.

THE COURT: Did you use that instrument in connection with your work evaluating this defendant's competence?

THE WITNESS: No. In this case I made my psychiatric diagnosis because I have, basically, wrote the SCID and the SCID's essentially has been internalized. I can formally use -- went through the entire SCID. I went through the depression section as well as the entire clinical interview. It's not a psychological test in the normal sense. It is something which is used to guide a clinical interview with specific types of questions. The questions I used are the

questions in the SCID.

THE COURT: Then what's the difference between what you did in employing the SCID in the course of the interview? Is there any difference?

THE WITNESS: It's only one part.

THE COURT: In other words, I have no psychiatric medical background. So to the extent you can be as jargon free as possible. If you have to use jargon, explain it in layman's terms. As I understand what you've said, you didn't use every part of the SCID. You just used a certain part, is that correct?

THE WITNESS: I used the general structure. Mr. Bejaoui as, it's been an extremely difficult challenge to interview him. Much of my interactions with him were simply to trying to develop rapport in trying to elicit psychopathology. When you actually use this SCID on a psychotic individual or an individual that is very impaired you, actually -- and this is true for when you use it on patients with severe mental disorders like schizophrenia and bipolar disorders, you often can't actually use this SCID interview because most of these patients are able to follow through with the sequence of questions.

So the SCID in that context is used as a structure to allow you to apply the DSM criteria. So in that context I use the SCID the way I would use it on patients with severe

schizophrenia which is to cover the overview sections which is to cover the individual's background and life and then apply the algorithm of using the historical information I've collected to the individual.

So I've used the SCID the way it's usually used. I didn't use it the way it would be used when I use it in a case of post traumatic stress disorder or depression when an individual isn't able to be a good historian --

THE COURT: If I understand, in certain instances, that is instances where the patient is a good historian of what's happened in the past, you use it in full.

THE WITNESS: Correct.

THE COURT: When you can't get a good history you don't use it in full but just use it to as a guidelines.

THE WITNESS: You are guided by the structure of the algorithm of the SCID.

THE COURT: Go ahead.

BY MR. DRATEL:

Q. With respect to the DSM, we're now up to DSM4, is that correct?

A. That's correct.

Q. What is your position with respect to the DSM?

A. The DSM4 the -- actually, the current one is the DSM4 TR Text Revision and that came out in the year 2000 and I was the editor and the co-chair of the Revision Task Force, so I was in

charge of that project.

Q. And do you have any teaching positions?

A. Yes. I am the professor of clinical psychiatry at Columbia University.

Q. How long have you held that position?

A. I have had been at that level for, I guess, about seven or eight years. I have had some academic position at Columbia since I finished my residency in 1988.

Q. And in the context of your practice, your private practice what kind of variety of patients do you see?

A. It's an outpatient practice on the Upper West Side of Manhattan, so it's a relatively high functioning practice of depression, anxiety personality disorders, bipolar disorder and the occasional individual with schizophrenia.

THE COURT: High functioning, meaning the clients are high functioning, their judges, lawyers and psychiatrists?

THE WITNESS: Right.

THE COURT: All right.

Q. Thank you, your Honor. Have you testified previously?

A. Yes, I have.

Q. Have you testified for the government?

A. Yes, I have.

Q. Have you testified for the United States government, for the federal government?

A. Yes, I have.

Q. Can you tell us about the case just generally?
A. Yeah. I testified on behalf of the U.S. Government in a case U.S. versus Pimentel and it was, actually, a Daubert hearing. Essentially, the defendant in that case made a claim that he had a condition called pseudologia fantastica which is a very jargondy term which is, basically, pathological lying. They had wiretapped his telephone and recorded extensive conversations of him arranging drug deals and a defense, they claimed that he had this mental disorder and this entire thing was a fabrication that is due to this mental disorder which is not a wide -- not accepted at all. So I was testifying on behalf of the government to make it clear that this was not an accepted diagnosis under Daubert standards and the government prevailed in that case.
Q. You testified for New York State?
A. Yes. I testified for New York State in a case again. There was an individual who was trying to get released from a mental hospital and we were trying, the state was trying to block that release. So I testified on behalf of the state in that case as well.
Q. Have you testified on behalf of the Canadian government?
A. Yes. It was a case with Omar Carter who was an individual who was when he -- a Canadian citizen who was in Afghanistan and he was arrested upon entry to the United States after having been in a prison in Pakistan and he had upon -- I am

sorry -- was upon entry to Canada and he had participated in some Royal Canadian Mounted Police and FBI interrogations in a hotel room, then after the fact they tried to have the interrogations dismissed on the grounds that he suffered posttraumatic stress disorder in the Pakistani prison. And I was testifying on behalf of the Canadian government in conjunction with the U.S. Government who had an interest in his case to the effect that he did not have posttraumatic stress disorder and that his statements should be accepted.

Q. You said Omar Carter was his brother Abdul Carter?

A. Yes.

Q. You've testified in civil cases?

A. Yes. I've testified in a number of civil case on both for the plaintiff and for the defendant.

Q. And in the context of the defense it's to -- can you explain --

A. Yes. Generally, in the way many civil cases work an individual is injured in some way through an accident or sexual harassment or some other tort action. And an individual suit claiming that they've developed some mental disorder as a result of this injury and when you testified for the defense usually what you are trying to establish is that the individual is either malingering or exaggerating or does not have the claimed mental disorder. So I have been involved in both the defense side as well as the plaintiff's side in such cases.

THE COURT: The defense's side you are saying is traditional. The defendant is malingering. The individual is malingering and when you are testifying for the plaintiff it's essentially what?

THE WITNESS: The individual has a genuine mental disorder. So malingering is a question on both sides. But when I have been on the side of the defense I have been involved in several cases for the New York State Department of Corrections. There have been not insignificant number of lawsuits brought against the Department of Corrections for a variety of reasons with many claims of posttraumatic stress disorder. And malingering, of course, is a big issue there. So when I have been on the side of New York State I've testified on behalf of the claim that the individual is malingering and that they do not have a legitimate claim.

THE COURT: Against the Department of Corrections?

THE WITNESS: Yes.

THE COURT: And can you -- how many times apart from the testimony in the federal criminal case, New York State criminal case, the Canadian government case how many times have you testified to this, civil cases?

THE WITNESS: For the side of the defense?

THE COURT: All together.

THE WITNESS: All together? In court relatively rarely because those cases usually get settled. I've actually

only gone to court on one of these civil cases twice. They almost always.

THE COURT: The two that you've testified to which side?

THE WITNESS: I was both sides.

THE COURT: And in general in terms of your being retained which side -- well, I guess that's not the question. Can you estimate how many times have you been retained by the plaintiffs and how many times by the defense?

THE WITNESS: At this point it's roughly in the civil cases, it's roughly even. It's probably -- it is -- I think it's even, maybe slightly more on the defense side than the plaintiff's side but it's relatively -- this is only -- I only do this, something on the side so that the cases come sort of through word of mouth or whatever they just come in, so they ended up falling down relatively towards 50/50.

THE COURT: Go ahead.

BY MR. DRATEL:

Q. Have you testified on behalf of a criminal defendant before or been retained by or acted even if it's court appointment?

A. Yes, I have on several cases.

Q. In federal court?

A. Yes. I testified on behalf the Zacarias Moussaoui several years ago in Virginia in that case in the penalty phase of his death penalty, the litigation aspect of the trial.

THE COURT: What was the substance of your testimony?

THE WITNESS: The -- essentially, the substance of my testimony was that Zacarias Moussaoui was suffering from schizophrenia and that because of the schizophrenia -- Well, that was the essence of my testimony.

THE COURT: All right. Thank you.

MR. DRATEL: Your Honor, I would move Dr. First as an expert in psychiatry and diagnosis.

THE COURT: I am going to allow his opinion testimony in regard to the competency of the defendant.

Proceed.

MR. DRATEL: May I approach, your Honor?

THE COURT: Yes, sir.

Q. Dr. First, I am going to show you what's been marked as defendant's -- well, first let me show you what's marked as Defendant's F. Can you tell us if you recognize that?

THE COURT: Is that your curriculum vitae?

THE WITNESS: Yes, it is.

THE COURT: Is that your report in this case?

THE WITNESS: Yes, it is.

MR. DRATEL: I move it into evidence.

THE COURT: Admitted. Next.

(Defendant's Exhibit F received in evidence)

MR. DRATEL: Thank you, your Honor.

Q. In preparing your report can you tell us what you reviewed

for purposes of making your report?

A. Yes. I reviewed the medical records from --

THE COURT: Did you review the sources of information listed on Exhibit A?

THE WITNESS: Yes.

THE COURT: First page and second page?

THE WITNESS: Yes.

THE COURT: Anything else?

THE WITNESS: I only reviewed -- I reviewed what was in the report, yes. So the answer is everything that I reviewed, everything when I wrote this report what was in that list of, was the complete list of all the sources of information.

MR. DRATEL: Very good, your Honor. Try to streamline that, that's fine.

BY MR. DRATEL:

Q. After the report was completed did you have an opportunity to review other materials?

A. Yes.

Q. Hospital records?

A. Since this report was completed the only additional materials that came to me were number one, the recent yesterday, in fact, I was sent the audio recordings of 12 telephone calls which I did have an opportunity to review. I don't believe there were any additional hospital records. One

of the gaps in the record the records from Rikers Island which remained inaccessible I was hoping I would see them. I also reviewed a request for records from Lutheran Hospital that had come back indicating that Mr. Bejaoui was, in fact, a patient at Lutheran Hospital in 1999 but that the records had been destroyed so that was something that I had reviewed since the time of this report.

THE COURT: You mean not the records but the statements.

THE WITNESS: The statements that the record existed cause there was a question about whether or not originally there was a question that the hospital claimed that Mr. Bejaoui was never a patient there. So since then --

THE COURT: I understand.

BY MR. DRATEL:

Q. You interviewed Mrs.~Bejaoui?

A. Yes, I interviewed Mrs.~Bejaoui as well.

Q. And you, obviously, interviewed Mr. Bejaoui?

A. Yes.

Q. At MDC?

A. At MDC, correct.

Q. How many times did you see him?

A. Five occasions.

Q. And what was roughly in terms of timeframe, how much time did you spend with him for each?

A. There are variable amounts of time. I think there are generally in the order of an hour 15 minutes.

THE COURT: You have it listed here in your first source of information?

THE WITNESS: Right.

THE COURT: Next.

BY MR. DRATEL:

Q. Now, you obtained some history about Mr. Bejaoui from Mrs.~Bejaoui?

A. Yes.

Q. How is that relevant to your report?

A. Well, it was quite relevant. Mr. Bejaoui is very poor historian, so Mrs.~Bejaoui filled in many gaps, most particularly, what his function was like prior to his incarceration at Rikers. She basically established a fairly convincing history, premorbid phobias, anxiety depression which had come out before but most interestingly, fairly significant history of paranoid ideation and behavior that possibly bordered on psychosis.

THE COURT: What does all that mean? What's premorbid phobia? What does that mean?

THE WITNESS: Premorbid basically means before he became ill, since he was in the prison system what he was like before that.

THE COURT: All right.

THE WITNESS: I'll avoid the jargon.

THE COURT: I don't mind you using the jargon. You just have to say what it means. Just a moment.

Possibly bordering on psychosis, what does that mean?

THE WITNESS: Well, what was reported to me was that Mrs.~Bejaoui said that Mr. Bejaoui felt that he was being watched and sometimes would stay in his house because of feelings that people were watching him and spying on him. So that's clear strong paranoid ideation with strong enough, actually, to affect his behavior. So when you are actually interviewing an individual to determine whether they actually truly psychotic, you'd want to know how convinced he was that he was being followed or spied on.

THE COURT: All right. So you learned from her -- and, again, it's in the report -- that before he entered the criminal justice system he was anxious at times. I believe they didn't have many social friends. He thought people were following him and watching him. Sometimes he wouldn't leave the house because of this. That's what you she told, right?

THE WITNESS: Yes.

THE COURT: Next.

BY MR. DRATEL:

Q. Did he also tell you that he had anxiety from stress prior to his incarceration?

A. Yes.

Q. And he was claustrophobic?

A. Yes.

Q. And that he had taken medication for depression?

A. Yes.

THE COURT: All right. So far you know we'll take this bit by bit so that I understand. I don't mean to slow you down except to the extent that I need to make sure I understand it.

THE WITNESS: Sure.

THE COURT: Before he entered the prison system he was an anxious person who thought people were following him?

THE WITNESS: Yeah. And also socially isolated. So he is not a high functioning well person and if that was the point --

THE COURT: But that doesn't mean he is suffering from or does it mean he is suffering from a mental disease or defect?

THE WITNESS: That in and of itself doesn't indicate that he was suffering from it now. It provides basis for understanding how someone with a long history of --

THE COURT: All right. It sorts of background information but, certainly, there are a lot of people who are paranoid and anxious and not terribly social who are able to understand the nature and consequences of criminal proceedings, correct?

THE WITNESS: Absolutely.

THE COURT: All right.

BY MR. DRATEL:

Q. Is that background relevant to your ability to make a diagnosis as to what someone might be? Let's leave Mr. Bejaoui out of it and talk generally -- is relevant to determining what a person might be suffering from currently?

A. Yes. With respect to trying to make a current diagnosis and longitudinal history that background provides a basis for understanding how someone may be predisposed to a stressful situation like being incarcerated, for example.

Q. Does it also -- is it also relevant in the context of trying to make a determination of whether one's malingering when you have that history at your disposal?

A. Yes. For example of an individual prior to presenting with symptoms that raise the question of malingering as an absence of any psychiatric symptomatology that would raise the suspicion of malingering because it would suggest that the entire picture of psychiatric suffering existed almost entirely, the context of the setting in which there would be secondary gain.

Q. Is it also relevant in the context of helping you determine which aspects of a person's psychology or personality might become more acute in a stressful situation?

A. Yes, yes.

THE COURT: I don't understand what you said. It would suggest the entire picture of psychiatric suffering existed almost entirely in the context of the setting in which there would be gain?

MR. DRATEL: Secondary gain.

THE COURT: What does that mean?

THE WITNESS: What I mean basically is if someone, if you have somebody who is arrested and goes into prison and develops psychiatric symptoms for the first time the moment they enter prison, been psychiatrically healthy with no evidence of a psychopathology prior to entering the prison system, when one enters the prison system immediately increases the likelihood that a psychiatric presentation might be used to get something --

THE COURT: That I understand.

THE WITNESS: The absence of any previous psychopathology would be much more highly suspicious than malingering in the presence of a significant long-standing history of psychopathology doesn't rule out malingering is helpful in suggesting that there is a basis of the existence of psychiatric symptomatology in the absence of context in which --

THE COURT: In my terms, let's see if you can accept this. If somebody's had psychiatric problems prior to entering a criminal system it suggests that the person is less likely to

be malingering than someone who had an absence of psychiatric problems prior to entering the prison system.

A. Yes. And also those particular problems that they had before are also less likely to be malingering.

THE COURT: I understand.

BY MR. DRATEL:

Q. You also reviewed medical records from MCC and MDC?

A. That's correct.

Q. And were those relevant to you making your diagnosis and conclusions?

A. Yes.

Q. And in what way, just generally? I know it's in the report, so if you just give us sort of a summary answer in that regard.

A. Well, the records at MDC and MCC provided a trajectory of development of his symptoms. It actually showed the onset started out with basically symptoms of depression and anxiety and pain and escalated to the point where Mr. Bejaoui became nonfunctioning. So the psychiatric diagnosis, of course, depends pretty much on symptoms, you know, documentation of symptomatology in trying to understand. And put those symptomatology together in a picture. So the records of MCC and MDC provide an important piece of being able to track the symptoms as they developed and how he presented.

Q. And at both places, MCC and MDC, he was diagnosed with a

major depressive disorder?

A. That's correct.

THE COURT: Is a major depressive disorder that that means the person is depressed, is that what a major depressive disorder is?

THE WITNESS: Right. It means that depressed, plus a number of accompanying symptoms. So, it's a term which refers to a particularly severe form of pathological depression. So when someone is depressed colloquially that could be normal to be depressed that you are in a difficult situation.

THE COURT: At some level. Again, just help me. At some level any right thinking person incarcerated would be depressed. So what is this?

THE WITNESS: The term -- that's why we use words like "major depression". It refers, specifically, to answer entitled in the diagnostic statistical manual which is a type of depression characterized by persistent depressed mood and total five out of nine symptoms like diminished interest or pleasure in activities, insomnia, difficulty in cognitive function, inability to concentrate, suicidal ideation, fatigue.

THE COURT: That's depression?

THE WITNESS: That is the syndrome of a major depression.

THE COURT: Is that by itself -- I take it that by itself does not mean somebody is unable to understand the

nature and consequences of criminal proceeding.

THE WITNESS: That's correct. No diagnosis by itself is not one -- one relationship between one diagnosis as competency, maybe the exception the severe depression but all the psychiatric diagnosis provide a framework for saying in the case of many, many people with that diagnosis of a major depression especially severe with psychotic features could be incompetent in many people with major depression or not.

THE COURT: All right.

BY MR. DRATEL:

Q. He was also medicated at MDC and MCC?

A. Yes, he was.

Q. With antidepressant?

A. Yes.

Q. Anticonvulsive medication?

A. Yes.

Q. Pain medication?

A. Yes.

Q. Antipsychotic medications?

A. Yes.

Q. Just to clarify, someone with a major depressive disorder could be incompetent depending on the other factors, just not the diagnosis itself as an automatic?

A. Correct.

Q. There's a wide range of depression, correct, in terms of

some people are depressed and internalizes. Some people can't get out of bed?

A. Correct exactly.

Q. Can't get out of bed for an extended period of time?

A. Could be totally disabled, right.

Q. Let's talk about your sessions with Mr. Bejaoui. How did you find him in terms of grooming and presentation, physical presentation?

A. Well, Mr. Bejaoui from a physical presentation was always very disheveled, very poor really, poor hygiene.

Q. That's what this report says?

A. Right.

THE COURT: Go ahead.

BY MR. DRATEL:

Q. If he could just give us some detail. I don't know if it's detailed in the report. If you could just give us some detail on how he presented to you physically.

A. Poor hygiene, hair was disheveled, an odor that showed that he had not showered. He was often dressed poorly. There was sometimes mucous on his clothes. The kind of thing you would, can see in an institutionalized person with either schizophrenia or major depression.

THE COURT: Or malingering?

THE WITNESS: Or malingering, of course.

THE COURT: I remember from one of the reports,

strands of mucous would trip from his nose and he would wipe it on his sleeve. Is that something you observed?

THE WITNESS: Yes.

THE COURT: That doesn't tell you malingering or not malingering, correct?

THE WITNESS: No, not at all.

BY MR. DRATEL:

Q. Would it be relevant if this kind of behavior occurred for a year?

A. Yes, if it occurred --

Q. A year and a half?

A. It's -- mayor depression can be chronic especially if untreated or inadequately treated. So that that is, would fit in with this level of severity.

Q. And did you administer some tests to him during the course of your sessions with him?

A. Only -- most of the sessions were characterized primarily by just attempting to get history, interview and establish rapport. And there was only one session where I did some testing which was mini mental status exam which is a rough assessment of cognitive function and the Georgia competency test. As well as, I also wanted to get a more quantified assessment of the level of his depression. I had already made a determination that diagnostically that he had met the criteria for mayor depressive episode. But that doesn't give

you a -- find a really good sense of the logical of severity. So I used a scale called the quick inventory for depressed symptomatology. So I also admitted, that was also administered at the same meeting I administered the other tests.

Q. Had that test been administered in of the other facilities?

A. I don't believe I saw any assessment, any depression scale used at any point during any assessment of him other than that time.

Q. And can you describe your interaction with him? In other words, your efforts to interview Mr. Bejaoui and how that -- what impact that this had on your ability to make a diagnosis?

A. Very difficult. I routinely when I see people for psychiatric evaluation and forensic settings I try to see them for several hours, minimum of three or four hours at a time. That was impossible. That is one reason why I had to see him over five sessions because after about an hour or so, there were a couple of peoples where he wanted to stop and after 30 minutes and I had to coax him to even get my hour and 15 minutes. So it was very, very difficult. There were long periods of silence, pauses, and a lot of difficulty getting any kind of coherent history.

THE COURT: I take it those are signs of major depressive disorder?

THE WITNESS: I think in this case it was that plus I believe that there is, as what I -- became the conclusion over

time it was that his paranoia and delusional thinking seemed to be playing a role in his unwillingness to speak to me. He was very, very paranoid about me, paranoid about any doctor. He is convinced that at one point in time he was convinced that I was trying to collect information, that he was a child molester. And he noted I was writing down and was convinced I was writing this material down because I was trying to collect information for him being a child molester. So I don't see his presentation as typical of the interaction of somebody who is depressed. It was a combination of his depression and paranoia which made him very reluctant and, basically, refusing to be cooperative at some level.

THE COURT: How do you decide -- and I realize I may be unfairly breaking everything down into the segments but that's the easiest way for me to approach it. How do you decide whether his, not his uncooperativeness that is his questioning what you are doing, his not wanting to talk for long periods of time, his inability or unwillingness to go on for the length of time you wanted? How do you decide whether those symptoms are the result of paranoia and delusion or malingering?

THE WITNESS: Import of it is the -- part of it is that clinical judgment of the interaction with him in the room. He is -- either you'd have to be -- it's one thing to say sit there and just say I am hearing voices. Anyone could say that.

There are certain factual statements are easy to malinger which is a statement. There's another thing to malinger. I mean, if you are Meryl Streep and you could act at a level of reality that creates an emotion. I could feel the paranoia, the anxiety that was very, very intense in the interactions. So he would have to be -- it's not just saying something of his history. There's bits of conclusion about the history. It's actual interaction. It's the -- so, it's not simply a statement of something. The level of --

THE COURT: In other words, you found it credible that he thought you were obtaining information about his being a child molester. Is that what you are saying?

THE WITNESS: Not only that. The only other thing is if he were malingering he would have offered that. What, actually, happened it was a very tortured interaction. It took three or four sessions. I finally felt that I was beginning to get enough of a rapport that the interview started going better after the third time and which is one of the reasons why I had formed this hypothesis. The paranoia was largely a huge factor in his poor performance in the interviews. And my hypothesis was that if that was the case it would make since that as some level of trust developed the interview would, the abilities to interact would improve over time. That was another reason why I made the decision to go so, sometimes rather than just once or twice being the more often the -- when at one point I was

going almost every week, week and a half to try and develop some sense of facility that he knew who I was. And as that was going on over time, I clearly felt some improvement and he was able and willing to interact with me.

But even in its best there was -- that's why where that interaction happened with that child molester -- I had heard right before that interview I had listened to the tapes, the recorded phone conversations that I was really struck about the huge difference between how he sounds on the telephone --

THE COURT: That's just what I was thinking about the -- he sounds like you are -- I don't know. It's building a case is probably the wrong word. I was thinking that indeed is your response to the government's position of ah-ha we caught you, being normal in your telephone conversations with your wife and friends. So it sounds like your position is, no, it's because he had trust in those people, so he didn't have the high level of anxiety that he had when talking with me and the others. Is that it?

THE WITNESS: When I heard the tapes for the first time I was very skeptical myself. I had seen him once or twice and saw how tortured the interactions were. Then I heard the telephone conversations. I was struck about sounds like a different way the guy on the telephone as someone I was seeing in person and I was very perplexed about that, what that could be malingering would be very reasonable thing to suspect in

that case.

So one of the things that I had done was when I saw him the next time I actually told him, I said I had an opportunity to listen to -- so when I actually asked him directly, I said, Mr. Bejaoui, I listened to these conversations and you sound like when you speak to your wife and to Riatt you sound like a completely different person. I don't understand this at all. Could you explain this to me. And he said that's because when I speak to doctors, I am scared and when I am speaking to my wife and Riatt I am happy and I feel comfortable. I said, well, what are you scared of with me? And he said, well, you don't have a club so you are not going to hit me. I said, so what you are scared about? And that's what he said about "I see you writing". I said okay. So he didn't immediately say -- again, if he were malingering he would come up with something right off the bat. Well, who knows what he would have said? But, again, it was the process, he said you are writing stuff down, okay. So what does that mean? I think you are documenting I am a child molester. And right before that the session the themes of this paranoia shifts from session to session. You know, come in there and one time the whole thing was about the fact that he believed that people were calling him a child molester. That was the theme. Everybody thinks I'm a child molester. Voices are telling me I am a child molester. That is what was on his

mind. So that fit in with his paranoia about me fitting in the picture of his being a child molester.

Here is what I am getting at is it fits to me a sense of clinical reality, the story, fit and experience of interviewing him fit what I felt the paranoia, it fit into the context of what he was talking about earlier, that meeting and the previous meetings about being a child molester. And so I felt that it was credible that his extreme fear and paranoia and I could see it in the room. It -- his interaction with me as a physician was really very, very difficult and I could feel the sense of and it also fit the -- I -- I could see the interaction with the doctors, both the medical doctors as well as the physical therapists. Every healthcare professional he interacted with there was this element of whether it was not cooperativeness or some negative interaction almost across the board, including people not just Dr. Cochrane and people who were in the position to evaluate malingering. He was like this with virtually everyone. A lot of it had to do with a combination of paranoia as well as he also had elements of personality disorder.

He is very demanding and he wants to be -- demands being taken care of, demands attention. There are lots of things. This is a complicated case. There's elements of his demanding style, his exaggeration and telling stories is to get attention. I think that there's -- he is not a completely

truthful person. That is what makes it such a complicated case.

THE COURT: But in a way, in a sort of odd way doesn't all of that suggest that the criminal case should go forward, guilt or not guilt adjudicated? And the man then goes out in society where he'd be a paranoid difficult person which is a totally demanding person but he won't have -- he won't be in an institution where he is constantly being questioned by people he thinks are adverse to his interests and he is not somebody with mental competency issues, just a paranoid, difficult, demanding human being?

THE WITNESS: The key question is, does he understand -- I guess, I am not -- my understanding is the issue is there is an interaction about, can this guy, is he competent even to plead guilty?

THE COURT: Absolutely.

THE WITNESS: That's been presented to him. I think I have a quote of this in my, from the telephone conversation with his wife or where his wife is basically saying, why don't you just leave already. And he is like, plead to what? I don't know what I am pleading to. And I can't see how that statement to his wife on a telephone call that he is not aware of being recorded is malingering. I think he honestly doesn't understand what the situation is, what he would be pleading to. He really is fixated on this old charge of harassment. And he

still he doesn't really have any kind of understanding of what the charges are and he has no ability to work with his attorneys about that.

So I agree with you. It would be -- he needs to be treated in a facility. And I have to admit I felt after my five sessions with him, optimistic that the proper setting could make -- he could get -- improve the -- how he did function at some point in years ago whether this experience in the prison system was permanently affected him is unclear. But I do believe that with psycho therapy and medication and a lot of work he can do better. But right now he is untreated and not able to appreciate his situation and not able to work with his attorneys. So that is why I felt in my opinion he was incompetent because he is simply not able to and I don't believe he is malingering, his lack of understanding of his situation.

THE COURT: Thank you.

BY MR. DRATEL:

Q. Now, you've reached some conclusions in your report. I am just going to reed them and then ask you some questions about them. Access one major depressive disorder with psychotic features and rule out schizo effective disorder, rule out psychotic disorder. Can you explain to me what rule out in that --

THE COURT: What page?

MR. DRATEL: 15, your Honor?

A. When I write reports I don't like having to use "rule out". "Rule out" is a phrase that we use in psychiatric diagnosis when we don't know, we're not confident in our diagnosis enough to say it's definitely this. Rule out is a way of saying the picture remains unclear and this other diagnosis that I listed after the word "rule out" remains given the information that I have a significant possibility. But given the information that's available to me now, there's no way in the world I could differentiate between the two.

Let me just explain that first major depressive disorder with psychotic features. I gave that diagnosis to describe the fact that he has severe depression and he is suffering from hallucinations and delusions that occur in the context of depression. So when people get very severe depression some people become psychotic. They hear voices. They have -- they become delusional and that's what that diagnosis means. Schizo effective disorder is what happens when delusion and hallucinations occur even when the person is not depressed. It's down -- it's getting to be down the line towards schizophrenia. And because the only way to make that differentiation is to have enough of the history to be able to find out what the relationship is between the psychosis and the mood. And Mr. Bejaoui is completely unable to provide that information. So that remains inconclusive. So that's

basically just saying that, yes, it is in this ballpark. I'm betting more on major depressive disorder with psychotic features but I can't rule out the other. That's what that construct means.

Q. Second, you don't differentiate the somatoform disorder. Can you explain that?

THE COURT: That's psychotic disorder.

THE WITNESS: Psychotic disorder NOS, I'm even leaving open the possibly that these voices are completely disconnected from the mood. So psychotic NOS, "NOS" stands for "not otherwise specified". Which is included in the diagnostic manual. The situation is so unclear all you can simply say is this person has a psychotic disorder. And I can't be more specific. I think it again applies to a case like Mr. Bejaoui where the history, the ability to collect a decent history remains so problematic that I am competent to say that he has psychotic symptomatology but the relationship of those symptoms to anything else are potentially questionable. So that's how you would express that.

Q. Undifferentiated somatoform disorder?

A. Also know question the significant part of Mr. Bejaoui's picture is his pain and not just pain. If you actually look through the record even though pain is by far the symptom which has preoccupied him the most, he's had on and off during his stay gastric problems, numbness and all kinds of other physical

symptomatology. So this is a section in the diagnostic manual. Those are when people present to doctors with physical symptoms for which a medical explanation can't be found and they often end up getting sent to the shrink to be treated. That's what we call somatoform disorder.

So Mr. Bejaoui, his primary presentation when this whole thing got started going in the wheelchair was the somatoform symptoms. So undifferentiated somatoform is a category that basically says that he has multiple somatic symptoms that are medically unexplained. And there's another diagnosis in the DSM called somatization disorder for people that have had symptoms for eight or more different areas. He doesn't have those problems to that extent. Plus that diagnosis requires an onset basically in young adulthood. So that diagnosis didn't fit. So that basically is a descriptive term to cover the fact that he has multiple physical symptoms for which no medical basis can be discover. And that's been much of the work of the -- established that there's no medical basis for his physical symptoms

Q. Would that mean though that someone doesn't feel pain just because there's no physical correlation on a test or some other diagnostic tool?

A. Right. It's accepted when people are suffering from somatoform disorder. It's -- subjectively these people have the physical symptoms. The fact that they can't be documented,

pain is a good example. Pain is in your head. It's a neurological phenomena. There is no way to objectively demonstrate that someone is in pain. You could look at markers of that, facial grimacing or things that would be correlated with how one might express pain. But pain is essentially a subjective phenomenon. So you are always stuck with the person has pain complaint. Pain's always been a challenge for physicians to treat because of the fact that there's very little objective evidence.

Mr. Bejaoui's case there is certainly inconsistent timings that raise the question about that there is something that's -- but, again, it's consistent to somatoform disorder. It shows the psychological rather than purely physical. It, again, is doesn't rule out malingering. People with malingering pain can look the same as people with real pain. But the fact that somebody is experiencing pain is not -- for which there's no medical explanation that in and of itself is sufficient.

Q. Doesn't mean they are not in pain?

A. Doesn't mean they're not in pain.

Q. The inconsistencies of the type with respect to Mr. Bejaoui feeling certain types of pain and without a clinical diagnostic verification is that something that you see typically in other somatoform disorders that you've seen?

A. Yeah. If Mr. Bejaoui were on the outside and presented

exactly the way he did, it would be kind of the same story. He would go to a neurologist, go to pain doctors and they would evaluate him. They would become, scratch their heads and after a while say, you know, this doesn't quite -- I think it's a psychiatric thing going on here. And he would be sent to a psychiatrist who specializes in somatoform disorders, not a malingering specialist. This is consistent with people who have chronic pain who are preoccupied with it and exaggerate at sometimes get more help. It's very typical of that, in that way Mr. Bejaoui's case is unusual in a lot of respects but the pain, chronic pain and how it's exaggerated and doesn't fit typical medical presentations is, unfortunately, not that unusual in regular medical practice.

Q. And also are these types --

THE COURT: Is this somatoform disorder subject to being relieved when the anxiety is relieved?

THE WITNESS: It's worse under anxiety. There is a huge co-occurrence of depression, anxiety and somatoform disorder. And the way we understand that is certain people express psychiatric symptoms in physical ways. I think I would understand in Mr. Bejaoui's case that his long-standing depression and anxiety at some point and especially now because of the prison, who knows why now, but it's gotten expressed in terms of his pain. I think it's just another expression of his long-standing psychiatric problems. But this time it's coming

out in terms of his complaints of pain. But he is still experiencing pain. It just doesn't fit the pattern of somebody who experienced pain of cancer or something of a more typical medical type.

Q. Just in terms of competency you've concluded that he does not, is not capable of understanding the proceedings or assisting his counsel?

A. Yes.

Q. And with respect to the competency part that concurred with the report done at Devens by Dr. Channel who found the same?

A. That's correct.

Q. And Dr. Krueger as well?

A. Correct.

Q. Now, you also --

THE COURT: Is he a danger in any way to himself or others?

THE WITNESS: Not to others. He says he has suicidal thoughts. I would say probably not. He seems too frightened. I don't really get a sense of him being the kind of person that actually attempts suicidal or anything. It's always a tough call to predict how dangerous he is but I would say he is no risk of suicide or being a danger to other people.

THE COURT: Put aside the legality of the lawyers and myself. If he is unable to understand the nature and consequences of the proceedings against him or to assist

properly in his defense and part of his symptoms are brought about by being in a prison setting, does that make sense to relieve him from the prison setting and would that help make him able to understand the nature and consequences of the proceedings against him and help him be able to assist in his defense?

THE WITNESS: In a sense it would. I think if he could be treated in a non prison setting he probably could be restored to competency. It's a is little bit of a catch 22, sort of like the process of being in the prison seems to be maintaining this condition.

THE COURT: Or worsening.

THE WITNESS: Right. If he could somehow be transported to another setting I think that he could be treated and supported to an ability to understand what his situation in the past two years understanding what is going on.

THE COURT: Is it your, within a reasonable degree of medical certainty is that more likely to occur in a non prison setting than in a prison setting?

THE WITNESS: It depends on the non prison setting. If he was put in the back ward of a psychiatric hospital and no one --

THE COURT: If he is not a danger to himself or to others to releasing him to his home?

THE WITNESS: The only problem with releasing him am

him to his home would, it's almost like he seems like the kind of guy who might need a nursing home. He's certainly from a danger perspective I don't see any reason why he couldn't go home. Whether that's the proper setting, he needs therapy. He needs a lot. He is seriously mentally ill and I am concerned that especially having listened to the phone calls and the wife and the whole setting, I am not confident that he could get brought to the proper treatment. The only way I would feel confident that he could get the treatment is that if he is in a setting where the treatment is there.

THE COURT: What are those settings?

THE WITNESS: Psychiatric hospital. I believe a psychiatric hospital where the goal is to treat him.

THE COURT: Well, presumably, there is no -- I shouldn't say this. I don't know. Is there a difference between a psychiatric hospital that you think would be ideal for him and the psychiatric hospitals that are run by the Bureau of Prisons for purposes of restoring people to competency?

THE WITNESS: I've never been to either Butner or Devens reading through the chart it didn't -- all I could say is the interactions between him and staff at Devens and Butner because it was the prison system, because of the constraints and the rules and I assume the fact that restoring to competency, I don't know how touchy/feely and I don't know what

the interactions between the staff and the inmates are with respect to -- I guess not having ever been there and reading through the chart would be that there was a sense of these had to reserve compensatory were it there to make this person better. I think he is extra sensitive.

THE COURT: I don't know if there's a difference between those two. Restore you to competency to me --

THE WITNESS: I said that wrong. I guess the sense of the context in which it occurs, the person is being treated because you want out of caring for that, it's a sense of caring. I don't know. Maybe it's possible that Butner or Devens, the inmates there who are treated do feel, I as a clinician in the outside world when I treat my patients they feel that I am there for the sole purpose of helping them and that forms the entire therapy. When you work in an in-patient hospital the entire thing resolves around the treatment. In the in-patient facility there is all this activity and this new setting of caring and that I presume not saying been to Butner or Devens, it's not the feeling of what it's like to be there. My sense is -- I may be mistaken -- that's not what it's like and that he responds to that lack of sense that this is a caring environment. I think he would respond very well to a caring environment. It even happened with me and very interesting when I was listening to last night the tape of a phone call after I stopped coming to see him between the time I

brought my report up to now there's a conversation with his wife where he became very upset that I wasn't visiting him any more. He seemed to get confused that I was there in the context of competency. He somehow must have thought I was his treating doctor. He was talking about nobody's here helping me. Even the doctor who is there he is not coming any more. Maybe he is lying to me too. I was able to get to the point where I think if I were there as his treating doctor I think I could have gotten somewhere with him. And I think as soon as that got pulled away he sort up of went back to being paranoid. So if he could be treated in a setting where he could appreciate the caring of what it would be like in a private setting as opposed to the way it works in a prison setting, the kinds of resources, obviously, mental healthcare in the prison setting is very, very limited because of the resources and huge need of Mr. Bejaoui can't really survive in the kind of resources available in a prison setting. I think that's the problem.

THE COURT: What's the alternative? This is not somebody who is going to pay for, extensive amounts of money for -- he doesn't have the resources of private care.

THE WITNESS: Right. But I don't know. I assume he could qualify for Medicaid and be treated in a one of the hospitals.

THE COURT: Why should anyone think there's a

different ambiance in state psychiatric hospitals than from Devens and Butner?

THE WITNESS: Part of the difference is even though you are in a state psychiatric facility -- I worked at a state facility. They're not like -- the hospitals that are left now, the people and the staff that work there they're really, generally, the care is very good as opposed to Butner and Devens there's a feeling about everybody is -- people get jaded working in a facility like that. I believe that that being jaded and expectation that everybody is malingering and everybody is not being honest as opposed to when you go to a state facility or hospital there's, nobody expecting malingering and I think the difference in attitude informs the treatment.

THE COURT: All right. Thank you.

BY MR. DRATEL:

Q. Something in Dr. Channel's report from Devens, if you can define for us conversion disorder?

A. Yes. Conversion disorder is a type of somatoform disorder in which somebody presents with a neurological symptom that is medically unexplained and what -- the reason that's particularly relevant here is just that the way you actually make a diagnosis of a conversion disorder somebody walks in and they come in saying I can't move my leg or I can't move my arm. The way that diagnosis is made is exactly the way it was made

at Butner as you do a careful medical examination. You find inconsistencies with the examination. You find a lack of objective evidence to support the examination. And that's your conclusion of conversion disorder. Again, people with that conversion disorder are presenting with something which is inconsistent but it's not considered to be malingering.

Q. Because it's not intentional?

A. Exactly. The person is not consciously doing. Somebody walks into a neurologist and says my foot is paralyzed. They really feel that they can't move their foot even though the neurologist knows that at some level he could if it weren't for the psychological block.

Q. You've obviously reviewed the report from Butner and disagree with their conclusions in that report?

A. Yes, that's correct.

Q. And just want to go through so many of the reasons why and there they are in your report. But Butner didn't administer a standardized evaluation competency?

A. That's correct.

THE COURT: Did you?

THE WITNESS: Yes, I did the Georgia competency test.

BY MR. DRATEL:

Q. By the way, did you administer any tests with respect to malingering?

A. No, I didn't.

Q. Why not?
A. Mainly because of -- I was sort of following the lead of Butner. Butner isn't -- neither Butner or Devens gave any tests malingering well and they had come to the conclusion that he wasn't being cooperative and I was basically doing, following my evaluation to assess both his in my clinical judgment his inability to understand, work with the lawyers, understanding, appreciate the situation and the basis of their diagnosis of malingering was laid out in their report fairly clearly. It was inconsistencies in his story and the recorded telephone conversations that I felt that I could address those directly.
Q. And with respect to, let's start with the telephone conversations first. You've listen to them, correct?
A. Yes.
Q. And you've also listened to another dozen or so over the weekend, calls that have been made since he was returned to MDC?
A. That's correct.
Q. And so in terms of in the context of the Butner report, if you could tell us why you don't find those telephone conversations determinative with respect to malingering?
A. I mean part of the -- I guess one of the big questions is when we talk about malingering what we're talking about what's being -- what the range of symptoms my diagnosis which is major

depression with psychotic features is what the question is. Is there evidence in the telephone? If this is a malingered case you'd expect there to be no evidence of any psychopathology on the telephone calls. And it is true and I think what happened with Butner is that there is a striking discordance between the cognitive functioning that he presents during his examinations in the hospital both with Butner staff as well as with me and how he sounds on the telephone.

And but also if you actually go through the calls very carefully and look at the content there are many, many examples of paranoia going to pure disorganized psychotic thinking that is -- so if he were -- usually, if he were malingering in the phone call were going to document that there was a normal person that presenting himself in a malingered way you'd expect consistency in that presentation, meaning that he would talk to his wife and to his friend without any evidence of psychopathology at all with the possible exception of some depression and anxiety which is what he has all had. But the key thing which is paranoia there's a whole section in there about him feeling that over and over again. They're trying to kill him. This whole thing about the idea that the MRIs is a ruse to give him ECT many examples where --

THE COURT: Ruse to give him?

THE WITNESS: Electric convulsive therapy. Two different phone calls where he became extremely agitated about

the idea that when they wanted to -- I assume he is referring to the fact the MRI was to check out his pain, I believe. And he also, those are unclear because sometimes the timing of that was unclear but paranoid idea, the idea that they're purposely trying to --

THE COURT: All right. So if I understand what you are saying that you are saying that the difference between the way he was speaking to the doctors on one hand, to his wife and best friend on the other is indeed striking. Nonetheless, and you can understand how that would suggest malingering. Nonetheless, you say if you listen carefully to those calls you'll see a presence of psychotic features and if he were malingering you wouldn't. And the features that you are specifically referring to are suggestions of paranoia. That is, they're doing this in order to give me electroconvulsive therapy. Is that right so far?

THE WITNESS: Yes.

THE COURT: Now, how do you get from there to unable to understand the nature and consequence of proceedings against him and/or to assist in his defense.

THE WITNESS: Also discernible on telephone conversations is his lack of understanding of his situation. On the most recent telephone calls he insists that his wife come to court with him because he says, I don't understand what's going on. I am not going to understand what's going on.

It is true that the level of, in Butner the psychologists at Butner make a very good point that the level of -- there's lots of inconsistencies and the level of cognitive impairment that he presents in his examination as compared to how he just talks on the phone. Obviously, he says he can't remember something at all. Somebody with a mini mal score of nine couldn't be having these conversations. It's completely inconsistent. Yet all through the calls there is over and over again, I don't understand what's going on. I don't know what that means. He doesn't remember things.

At one point he remembers the name of his lawyers. Two phone calls later is back to calling them "lady lawyers" and "guy lawyers". I saw him five times. Every time I made it very, very clear what my name was and the best he could call me on the phone calls was "that man doctor". He couldn't even relate to his wife that I was a psychiatrist. So there is, you know there is clear evidence of cognitive impairment, clear evidence of psychosis. It's not to the extent that it appears when you see him in person but I think that the big question is his gross poor performance intentionally produced in order to make some malingering point for some unclear secondary gain or is it a function of his paranoia? And I believe that, A, I don't understand at this point what the guideline is for him to be.

THE COURT: Well, that's a whole separate issue.

THE WITNESS: I think it's an important issue. Actually, the diagnosis malingering, at least according to diagnostic manual requires the secondary gain. There has to be so many obvious -- there's another diagnosis that's in my report.

THE COURT: No continue on that thought. "Secondary gain". Go ahead.

THE WITNESS: There has to be a reason because there's another diagnosis that I threw out in my report called factitious disorder also known as Munchausen where people also feign or exaggerate symptoms. That's considered to be a psychiatric disorder and not malingering. The difference between the two is the person's motivation. In Munchausen people go too hospitals. They say they're ill they even do things to make pretend they are ill and they get admitted to the hospital. The difference is their motivation for doing that is they want to be taken care of. But I think actually there's a lot of strong evidence in Mr. Bejaoui that there's an element of that. This constant nobody's taking care of me. I want to be taken care of. The whole business about the wheelchair, the motivation for being in a wheelchair and all is that he needs attention and caring and this is his way of getting it. So I think it's, yes, he is exaggerating but that's not malingering. There is something wrong with him if he resorts to doing this behavior in order to get attention.

So that's why that diagnosis factitious disorder is a psychiatric diagnosis covers much of this picture as well.

Malingering is diagnosed as a situation that's made sort of by exclusion except that there's an obvious thing. Somebody is suing somebody for a million dollars. There is answer obvious gain. Somebody is on trial for murder and they say, I am hearing voices. On an MGRI it's obvious, again, what the secondary gain is in this particular case at this moment in time and even from the beginning, the secondary gain that is central to the diagnosis of malingering, the idea that somebody may be feigning or exaggerating I think it's another big difference in our report.

I think the Butner report is saying, well, if somebody is feigning then the malingering may completely downplay their really didn't have, not really addressed their report the central question about why would he be feigning. And one of the other reasons why Mr. Bejaoui might be exaggerating his symptoms other than malingering.

Normally, when you do, at least from my perspective, when you are trying to figure out among different diagnostic cases you consider each one and say I've considered this diagnosis and I am not making this diagnosis for this reason.

And I think Butner has clearly made a good case for exaggeration of symptoms to the point of even outright lying and they caught him in multiple inconsistencies but then their

conclusion that therefore he's malingering and he is competent is a huge jump there and I don't see the connect the dots.

THE COURT: There have been suggestions and I don't know what the immigration law is here but there have been suggestions throughout this case that what he is trying to do is avoid removal from the United States because I believe he is not a United States citizen which I am told is more likely upon a conviction than not. That may be a secondary gain.

THE WITNESS: I guess if that's possible though he did say to me in a previous interview that he wanted to -- in order to get treated for his intractable back pain he was claiming to go to Tunizia. He wanted to leave the country. He was -- he said this over and over again. He is so upset and desperate about the fact that his life has been ruined by his back pain and loss of memory, he'll do anything to get treated.

Two visits ago he started this business about, I really want to go to Tunizia. A friend there has a doctor there and I am all ready to go. I'll do anything to get better. So the idea that this is all being motivated by a desire to stay in the United States I think is, all of this I find a little hard to --

THE COURT: All right. I understand. You started to go down this road already under questioning from Mr. Dratel. But essentially in your mind, your view, you as a psychiatrist, what did Dr. Cochrane do? In other words, what led --

obviously, you assume good faith on the part of everybody. What led to the conclusion of Dr. Cochrane that there is malingering here that you think was in error?

THE WITNESS: My analysis is in general I think there's no question that there's evidence of exaggeration and feigning and certain aspects of this presentation I think we both agree on that. And I think that the -- my reading of it is the generalization, if he is lying about this then everything is lying.

But the psychosis in particular as far as I could tell from reading from the Butner reports, the entire idea that Mr. Bejaoui has any psychotic symptoms was even that Dr. Channel -- I don't find that he is credible without any explanation of why. And there are just basically dismissed. In fact, he was pulled off of his antipsychotic medication and shortly after since he's been pulled off his antipsychotic medication he remains paranoid and psychotic.

THE COURT: Again, help me. What are psychotic symptoms? You talk about that throughout. Is that different than paranoia?

THE WITNESS: Paranoia is a favorite of psychiatrists. Psychotic symptoms is a general case. So if somebody is out of touch with reality they don't know. They are miss -- like for example, he believes that I am writing down -- my writing means that I am trying to accuse him of being a child molester.

That's taking something in reality and he is given a wrong belief, out of touch with the reality of the situation.

So I think that that whole aspect, I think that the Butner work-up really focused a lot on the pain and the misrepresentation of the physical symptoms and sort of gave the -- and the cognitive. On those two aspects and the depression and the psychotic symptoms which are from my perspective are the main psychiatric diagnosis were hardly addressed in their work-up and then sort of said, well, if he is malingering, if this picture doesn't fit I think that is from my perspective one of the mistakes, is an overgeneralization that he is malingering on this one bit there.

THE COURT: What tells you that the psychotic part of it is not malingering as well?

THE WITNESS: Well, part of it is since their, one of their main tools for proving the malingering was the discrepancy between the recorded conversation and the presentation in the unit.

THE COURT: You find the psychotic aspects in these telephone calls as well?

THE WITNESS: Exactly. And the depression as well.

THE COURT: What else, if anything? The general thrust of what you are saying is where Butner went wrong was they are dismissing the "out of touch with reality" aspect that

you find as genuine. They find as part and parcel of the malingering. Is that fair?

THE WITNESS: Also the depression. I think they -- I think he has major depression. I got a score of 21 out of 27 on the quiz which is the bottom end of very severe. Their diagnosis was -- I believe it was adjustive disorder with a depression given to show that people in prison get depressed and anxious because it's a bad situation. I think there's also a sense that Mr. Bejaoui suffered from severe depression and malingering as well. So those major diagnoses are their opinion, not real, without -- again, I think they've sort of got generalized. I don't think they present any evidence one way or another. They sort of assume it's not there.

One last point about -- in addition, what my clinical evaluation after five sessions I found that his presentation to me is consistent with somebody who has major depression of psychotic features, a combination of both. I feel that they are dismissing of that diagnosis because of their assertion of malingering. Plus on the positive side, I felt that the picture fit indeed someone who did not major depression of psychotic features. On top of everything else he has personality disorder, paranoia and somatoform. That picture fit together and a Butner decision that it could be dismissed based on those discrepancies, I felt was over generalize.

THE COURT: All right. That's helpful. Thank you

sir.

BY MR. DRATEL:

Q. Just talking about more specifically about your issues with the Butner report in terms of selectivity how they viewed the evidence in the sense. Let's talk about, for example -- well, you want to talk about the phone calls, right, that he used the phone calls for one purpose and yet ignored the evidence that was contrary to that. Is that a fair statement?

THE COURT: Ignored the evidence in the phone calls?

MR. DRATEL: Yes.

Q. Sorry. Ignored evidence that was supported --

A. They didn't use the evidence. "Ignored" is a stronger word.

THE COURT: Gentlemen, I prefer the conversation that you are having but unfortunately we can't do it that way because of the requirements of the records. So try to give each other a little breathing room. I get that you are both New Yorkers when you speak.

MR. DRATEL: I'm sorry, your Honor.

Q. In terms of how they analyzed the telephone calls, also in your report you discussed the incident with the MRI. If you could just give us a summary of that. It's page 167 of your report.

A. Thank you. Yes. I think it's another example of how -- I guess part of what I am implying there is once the idea of --

this is a very common phenomenon. One of the reasons we developed the SCID interview is to prevent people from doing what they always do which is to very quickly come up with an initial gut feeling and then whatever information that you see, the stuff that supports that gut feeling get's elevated and stuff that goes against it gets discounted like a huge bias. And there's several examples. One of the better examples, he has been noted to be uncooperative. Here is Mr. Bejaoui in a lot of page --

THE COURT: What page are you on now?

MR. DRATEL: I think it was 17.

THE WITNESS: No. Actually -- yeah, it's 17. There's many examples of so-called evidence.

THE COURT: All right. I have it. Go ahead.

A. So the example we're discussing, there was the idea that they were pointing out that his refusal to get an MRI was evidence of malingering. The idea it kind of makes sense if somebody is in severe pain and they refuse treatment you have to wonder is the reason they're refusing treatment is they don't want a doctor to look too carefully at it because they don't want to discover the malingering. That's, certainly, among the reasons you would expect, you would be worried somebody is refusing treatment is if they're distressed. If you, actually, look carefully it turns out -- here it is. So, basically, the neurologist came. Basically, what happened was

he is in severe pain. They called the neurologist to see him. Mr. Bejaoui is completely uncooperative and, basically, refused to allow him to examine him and that happened on more than one occasion where he would be screaming out for pain and then when they finally would come to help him he would be uncooperative. And one of the ways that was presented was this is the kind of thing that somebody was malingering would do. But if you actually read more carefully the neurologist noted -- the neurologist pointed out that Mr. Bejaoui was worried that he was going to -- the neurologist was going to find out his home address in order to take away -- take his ten year old daughter away from him. So he is paranoid. So his refusal for treatment was motivated by the paranoid ideation and delusions that he's been plaguing him and not by malingering.

So, again, it is an example of a certain behavior than on the surface could be used to support a diagnosis of diagnose of malingering. And if you are trying to build a picture like, I think this person is malingering and this -- the pieces of the puzzle start falling in. And if you look at it and say, okay, I'm file this away under malingering, when in fact the same behavior, if you look a little for deeply all you'll see it is not feeling of malingering but, actually, supports, explanation, the reasons why he has poor interactions with healthcare professionals is his paranoia.

Q. And was there also in that same context with respect to the

tapering of antipsychotic medication and then the reappearance of some psychotic symptoms?

A. Right. He was stopped -- the medication was stopped again because of a decision that he was not ever psychotic. There was a whole -- all through the report there were just statements, yeah, it seemed to be clinical judgment on the part of the staff at Butner that this didn't seem real to them. I think it's, at least in my experience, having treated a number of patients with psychosis, I almost never dismiss a psychotic symptom based solely on how bizarre it is. There are some questions -- and it's possible that Mr. Bejaoui in his certain circumstances, at certain times he is, when he talked about a couple fantastic examples, it is possible they're exaggerated. But, again, it doesn't mean that the fundamental, there are so many examples of paranoid ideation. The fact of his behavior that there is an underlying psychosis there. The whole issue of hearing voices was dismissed by the staff at Butner simply saying that we don't think they're credible.

But I found the opposite. I found his getting him to admit that he was hearing voice was actually very, very difficult. I found that usually people who are malingering or volunteering the voices as an excuse, I had to fight with him to get the voices.

MR. DRATEL: If I, your Honor, in the streamlined way that the Court did, I have the reports from Dr. Cochrane which

is Defendant's B as in "boy", the report from Devens from Dr. Channel, Defendant's C as in "Charles" and the report from Butner as Defendant's D as in "David" and if I might move those in evidence I think without objection, your Honor.

THE COURT: Admitted without objection.

(Defendant's Exhibits B, C and D received in evidence)

MR. DRATEL: Does anybody need copies?

THE COURT: How much longer do you have?

MR. DRATEL: Probably ten minutes or so, I think.

THE COURT: All right.

BY MR. DRATEL:

Q. With respect to the Butner report, I just wanted you to look at page 14. I have it here for you. It's page 14.

This is at a time right after his antipsychotic medication is tapered off or discontinued. And if you look at the last paragraph then he's seen. And is it fair to say that this sort of demonstrates that without any antipsychotic medication he is going to be have to more outlandish and outrageous episodes?

A. Yeah. It would appear that, certainly, from his sequence-wise we have just to be clear risperidol is the antipsychotic medication used to treat symptoms like delusions and hallucinations. So after the medication is decreased we see a resurgence of this symptom. He was talking about this entire delusional account of --

Q. Goes on to page 15?

THE COURT: Is this the paragraph that begins "when assessed by the psychiatrist on 2/13/12"?

MR. DRATEL: Yes, your Honor.

THE COURT: I'm reading it.

THE WITNESS: The top of page 15 is where you really see the delusions coming out. And this is, again, it certainly -- normally when you cause and effect in psychiatry is very difficult but temporal relationship is usually one of the stronger indicators of cause and effect. Give somebody medicine, they get better. You take them off, they get worse. It's about as good as you can get with respect to the cause and effect. So in this case it's a strong presumption here that he goes off the medication and psychotic symptoms get worse, at least his willingness to discuss it with the staff. Now, that -- which is often his psychotic symptoms get more intense. People are often more willing to talk about it.

Q. Can you describe a term "malingering well"?

A. Yes. "Malingering well" malingering means, basically, deceiving the clinician about one's presentation. The kind of malingering that is most commonly talked about malingering ill which is that you are deceiving the clinician to look more ill than you actually are. The opposite, which we see a lot and I have had personal experience on, the Moussaoui case when somebody is a malingering well which is denying the presence of

the psychiatric symptoms to look healthy when in fact they're ill.

Now, in Mr. Bejaoui's case he -- it took a -- the whole issue about hearing voices was something that I had to pry out of him after a couple of sessions of establishing trust where, that I had known from the chart that hearing voices was an issue and I had them originally, my first couple sessions about hearing vices and he denied it. But eventually I got -- I questioned him again and discovered that, yes, he was hearing voices. Why aren't you telling me this? And he said A, I don't want you to think I am crazy; b, I don't want you to put me on the risperidol because it affects my memory an C, this is where I discovered something which came out in the history that I hadn't seen before or anywhere else, that his brother who died of diabetes, actually, developed diabetes as a side effect of antipsychotic medication and he died. And Mr. Bejaoui was frightened of taking the antipsychotic medication because of that. So that is another reason why he was covering up the fact that he was experiencing voices at least during this interaction with me. So I think --

THE COURT: Is the fact that his brother died due to antipsychotic medication, is that a delusion?

THE WITNESS: That's a good question. I have no way of tracking down the truth of that statement. But it explains -- it's an explanation of why he would not want to

take any antipsychotic medication. It's been reported in the chart over and over again for virtually every evaluation of whether his brother was deceased of diabetes at a very young age and this is the first time it came out that his brother, actually, was in a mental hospital and had received antipsychotic medication and developed diabetes from that that happens.

BY MR. DRATEL:

Q. Just to be clear, that a side effect of risperidol is diabetes?

A. Can be, yes.

Q. Okay. So that's not delusional?

A. Right.

Q. That's a pretty specific statement in terms of it's not one of general knowledge necessary to the public?

A. No. No. Probably not. It's not a secret but it's probably not something the average person would know.

Q. Also, did he deny seizures as well at one point in the course of reviewing the medical records did he deny also that at one point they also thought he had seizures and he later denied that?

A. Yes. At one point there was a claim of seizures that he had seizure and it looked like here is another example of him feigning a symptom. But in the record he actually said that the -- I was slumped over and the guard thought I had a seizure

and that's how I ended up in the hospital. So, again, he is denying a symptom rather than overreporting. So this seems to be the opposite where he is actually giving less information and trying to make himself look healthy than he may actually be.

Q. Now, in terms of exaggeration just for sake of arguments, saying, lying about severity of a particular condition, what one of your diagnoses I think is personality disorder NOS with histrionic and schizo typal features?

A. Yes.

Q. Can you explain that in the context of that particular part of his presentation?

A. The personality disorder NOS is what's used when someone has a personality disorder that doesn't conform to one of the full syndromes in the DSM. What you do, it turns out that most patients actually have a mix of features from several different disorders. So the term "personality disorder NOS" reflects the fact that he has a combination of histrionics. And histrionic features cover as a style of exaggeration, so people -- for attention seeking. And I think there is lots of evidence in the chart, not so much during my interactions but the chart both the Devens, at Butner and also at MDC of him being dramatic in his presentation about his pain and other, just dramatic in general, throwing temper tantrums and other behavior like that that appear to be part of his general

personality style. And I give a schizo typal partly to cover his social isolation and sort of general paranoid demeanor which I think may be part of his personality. In addition to him becoming delusional in a paranoid way I think he probably is as paranoid as part of his personality as well.

THE COURT: Just a moment. Schizo typal is S-C-H-I-Z-O-T-Y-P-A-L?

THE WITNESS: Yes.

THE COURT: How would you spell risperidol?

THE WITNESS: R-I-S-P-E-R-I-D-O-L.

BY MR. DRATEL:

Q. And with that, the personality type that you just discussed in that particular diagnosis would that negate the diagnosis of major depression that you made?

A. No. They often -- personality disorders often occur with other disorders.

Q. Does it indicate a psychotic features part of that?

A. No. No.

Q. And in addressing the type of disorder that you diagnosed with respect to Mr. Bejaoui, would a five week period that he spent at Butner be sufficient to restore him to competency in your opinion?

A. Almost never. Through some miracle it has -- he has severe complicated case of severe depression with psychotic features. This is the kind of thing that would require generally very,

very aggressive treatment. It's possible the five weeks but he didn't actually get, he didn't got any treatment, virtually, no treatment at all. So I wouldn't -- five weeks of aggressive treatment might be able to -- five weeks of evaluation without any treatment would not restore competency.

MR. DRATEL: Thank you very much, doctor all.

THE COURT: All right. Let's take ten minutes.

(Recess)

THE COURT: Cross-examination.

MR. DRATEL: Your Honor, Ms. Barrett is here. I don't know if the government wanted exclusion on that.

MS. KOVNER: It must be a reason for her to be here.

THE COURT: It's also a separate issue. If you want, we can take her out of order. It's up to you.

MR. DRATEL: No. It may affect my decision.

THE COURT: All right. Let's go forward and we'll break at one o'clock, just five before.

CROSS-EXAMINATION

BY MS. KOVNER:

Q. Good afternoon, Dr. First.

A. Afternoon.

Q. Can you explain the difference between a general psychiatric inpatient unit and the forensics psychiatric inpatient unit?

A. The biggest difference is that the -- in a forensic unit

the individuals in the forensic unit are under some kind of forensic context, arrested or already incarcerated for some reason as opposed to general unit where they're not.

Q. Now, you've done several internships as part of your -- Sorry. You've done an internship as part of your medical training?

A. Yes, that's right.

Q. But you never interned on a forensic unit?

A. That's correct.

Q. Since completing your training you've done hospital, you have had a hospital position, right?

A. Correct.

Q. But you've never worked on a forensic hospital unit?

A. That is correct.

Q. Now, can you explain what aboard certification is?

A. In general board certification is the process by which you are part of an organization that specializes in a certain area.

Q. You were board certified in psychiatry?

A. That's correct.

Q. There are board certifications in forensics as well?

A. Yes.

Q. You are not board certified in forensics?

A. That's correct.

Q. Now, one of the issues in a forensic analysis is whether a defendant is malingering?

A. Yes.
Q. And defendants in criminal cases often have incentive to malingering that other psychiatric patients do not?
A. Correct.
Q. Do you know what the psychological literature says about the percentage of people malingering in competency and responsibility cases?
A. I don't know precisely what it's -- I assume it's high.
THE COURT: I think I read somewhere that it's eight to 17 percent. Does that sound reasonable?
THE WITNESS: Yes.
THE COURT: All right.
BY MS. KOVNER:
Q. How many defendants have you evaluated for competency to stand trial?
A. Two.
Q. You've testified on your direct about cases in which you've testified as a government witness before. None of those were competency cases?
A. That's right.
THE COURT: Is it two in addition to Mr. Bejaoui?
THE WITNESS: Yes.
Q. Have you ever testified in a competency case before?
A. No. Incorrect. Yes. It was a state case, yes.
Q. Now you've published more than 50 articles in your work as

a psychiatrist, right?

A. Correct.

Q. Were you ever published in the area of competency to stand trial?

A. No.

Q. Ever published and subject of malingering?

A. Yes.

Q. Which publication was that?

A. PTSD and malingering.

Q. Can you explain the difference between a clinical psychiatric evaluation and forensic evaluation?

A. There are many differences. One is a lack of confidentiality and the forensics evaluation as compared with the clinical evaluation. The goals are different too. The goals of a forensic evaluation are usually specific to answer a specific question that's been posed as opposed to a clinical psychiatric evaluation.

Q. In a forensic evaluation your role is to serve as neutral evaluator?

A. That's correct.

Q. You understand that the judge is going to make a determination of competency or incompetency based in part on the observations that you put in your report, right?

A. Yes.

Q. And there's as objective evaluator you should present both

the evidence that supports the conclusion that you ultimately drew and the evidence, isn't that right?

A. Yes.

Q. Now, one of the tools that you used in this case to diagnose Mr. Bejaoui was in-person observations?

A. Right. Yes.

Q. You said you tried to see people for a substantial period of time before you make a diagnosis, right?

A. Correct.

Q. It was hard to evaluate Mr. Bejaoui in your in-person sessions, correct?

A. Yes.

Q. Would you concede that observing a patient on multiple occasions more rather than fewer is useful in reaching a correct diagnosis?

A. Yes.

Q. And it's useful in detecting malingering, correct?

A. Yes.

Q. And observing a patient who doesn't know that he is being observed is also useful in assessing malingering, correct?

A. Yes.

Q. Now, the defendant's responses to your meetings with him contributed in your findings that he was not competent, correct?

A. Correct.

Q. And to take one example, you said that you visited him five times and you wrote in your report that it was only by the third visit that Mr. Bejaoui acknowledged he had seen me before, right?

A. Correct.

Q. And it was only by the fourth visit that he could recall you were a doctor, is that right?

A. Correct.

Q. And you wrote that he was never able to remember that you were a psychiatrist?

A. Correct.

Q. And he was never able to remember your name, is that right?

A. That's correct.

Q. Now, you've diagnosed many patients with major depressive disorder with psychotic features, right?

A. Yes.

Q. And in general, what percentage of those patients would you say are unable to recall that you are a doctor or psychiatrist?

A. In the context in which I've seen them would be zero because I've seen them privately or in a hospital setting where I was -- In fact, I am -- it's complicated. I've made the diagnosis in research settings often where the issue of what where a name would be didn't come up, but it's complicated. I guess I've seen repeatedly -- I've never had a situation where they haven't remembered my name.

Q. Okay. Let's turn for a moment to the prison calls. You indicated that you listened to those calls in reaching your diagnosis?

A. That is correct.

Q. And, in fact, you indicated on direct that when you first heard those calls you thought a suggestion raised by those calls was malingering, correct?

A. Absolutely.

Q. And you testified on direct that you asked Mr. Bejaoui for an explanation of that, right?

A. Yes.

Q. And he gave an explanation in substance that he is comfortable with his friends and family but that he didn't trust doctors?

A. In substance, right.

Q. That's an explanation that Mr. Bejaoui gave you?

A. That's right.

Q. And I'd like to play a few brief clips from the phone calls. If we could start with the call on March 3rd at 5:41 p.m. I'd like to play a section of that clip. And if you are following there are transcripts for convenience. And the transcript of this call is Government Exhibit 19. The section that we're going to play is on page 3 line 31.

MR. DRATEL: Your Honor, it's not in yet. You want to put the calls in?

THE COURT: Government?

MS. KOVNER: Your Honor, there's a stipulation between the parties. I'm not sure under the circumstances we need to read it into the record.

THE COURT: Let me see it.

(Pause)

THE COURT: All right. Why don't you give this stipulation a government number. Does it have one?

MS. KOVNER: It does not, your Honor.

THE COURT: Just give it a number and we'll put it on there.

MS. KOVNER: Government Exhibit 40.

THE COURT: Four-zero.

MS. KOVNER: Yes.

THE COURT: We'll make this stipulation Government Exhibit 40 and I am admitting the exhibits set forth in this stipulation, specifically, Exhibit 5, 25 to 29, 6 to 24. In other words, it's Government Exhibits 5 to 29 are admitted.

(Government's Exhibits 5 - 40 received in evidence)

MR. WILSON: Your Honor, it may be that there is a typo in the stipulation it should be to 39 and I apologize if that's our error.

THE COURT: Well, it's some typo but Paragraph Two now says Government Exhibits 25 to 29. You want that to be 39?

MR. WILSON: Yes, your Honor, I do.

THE COURT: I'll do it right here, Mr. Dratel.

MR. DRATEL: No problem.

MR. WILSON: I apologize, your Honor.

(Pause)

THE COURT: Being generous we'll call it a typo. All right.

MS. KOVNER: Could you play March 3, 5:41 p.m. that first clip.

THE COURT: Does it have a number?

MS. KOVNER: The calls are simply one CD Government Exhibit 5.

THE COURT: All right.

MS. KOVNER: But the transcript is a Government Exhibit 19 and the excerpt we're going to play begins on page 3, line 31.

(Audiotape played)

BY MS. KOVNER:

Q. Just to be clear, Dr. First, do you know who Dr. Herbel is?

A. Yes.

Q. One of the --

A. Psychiatrists.

MS. KOVNER: If we could play a second clip. This is March 12th at 5:26 p.m. The transcript is Government Exhibit 23. And the section that we're going to play begins on page 2 at line 11.

(Audiotape played)

MS. KOVNER: And if we could play one final clip. This is also March 12, 5:26 call and this is the section starting on page 4 at line 7.

(Audiotape played)

BY MS. KOVNER:

Q. To be clear, Dr. Cochrane who is referenced in that report is the evaluator at Butner, correct?

A. Correct, yeah.

Q. Is the level of understanding of who his doctors are that the defendant displayed in his call, these several calls consistent with the lack of understanding of doctor identity he showed in his interviews with you?

A. It's hard to say because I don't know how he was introduced to those two doctors, how often that was reinforced or the fact that he had the name of Herbel down, I'm not sure that I could -- if somebody asked me without ever meeting Dr. Herbel, had ever seen his name written down requested or asked me to spell it, I presume I wouldn't be able to do it. I actually don't know what's going on, whether that was inconsistent. It's hard to say.

Q. You listened to those calls in making your evaluation of defendant?

A. Yes.

Q. And you concluded that there was not much significance to

his recollection of the doctor's names because he could have met them in a different context because you don't know enough about the context?

A. Right and/or the fact that he couldn't remember my name, I wasn't -- that's a small crumb of information. My report and conclusion did not depend upon the fact that after five times he couldn't remember my name. He continued on the tapes that were sent.

Q. Okay. So let me move on.

MR. DRATEL: Could he be permitted to finish?

A. I was going to simply say that the tapes that I heard, since he met me he continues not to remember my name. So maybe hear it, I don't know. I am not making much of it at all. I was just commenting on the fact that he did.

Q. Let's move on to some of other things the defendant said in his interviews with you and his interviews with the other doctors. You are aware that the defendant had told the evaluators that he was 50 years old?

A. Yes.

Q. And you are aware that the defendant was in fact 58 years old?

A. Yes.

Q. And you are aware that the defendant told one of the people evaluating him he couldn't recall his own first name?

A. I am aware of that.

Q. As you indicated, you've treated many people with major depressive disorder and psychotic features?
A. Yes.
Q. What percentage of patients would you say give a wrong answer for what their age is?
MR. DRATEL: I would object to that question, your Honor.
THE COURT: I'll allow it. You mean in general or those he's --
MS. KOVNER: Those you have treated.
A. I've never had somebody who I've asked their age give a wrong age, at least not by that much.
Q. Are you aware of the ability to remember your name and your age and your date of birth are relatively preserved in, even in patients with amnesia?
A. Yes.
THE COURT: How do you account for his response?
THE WITNESS: As being uncooperative or frightened, paranoid, I agree it's inconsistent. I am not arguing that there are a lot of things said that appear to be inconsistent and not truthful and so these examples are good examples. You are right. These are not credible. For somebody to get these wrong due to major depression, they would be almost moot. So I agree. These wrong answers I think are not really explainable simply by the kind of cognitive appearance one sees in major

depression. I agree with that.

Q. Are you familiar with forensic tests designed to assess malingering?

A. Yes.

Q. Can you give examples of some of the most common malingering tests?

A. The MMPI, the PAI are two that I FIND helpful. The certificates and the TOMM, T-O-M-M.

Q. There are some of these tests that patients with depression do quite well on, right?

A. They can, yeah.

Q. And some tests that patients with psychosis have been documented to do well on, right?

A. Yes.

Q. Now, for purposes of your evaluation of the defendant you gave three tests, right?

A. Yes.

Q. You gave the mini mental status exam?

A. Right.

Q. And the Georgia core competency test?

A. Yes.

Q. And you gave the quick inventory of the --

A. That's right.

Q. You rely in part on the defendant's responses to these tests in making your diagnosis, right?

A. In part yes.
Q. In make your conclusion about competency?
A. In part, yes.
Q. So let's start by talking about these tests. And I'd like to start with the mini mental status exam?
A. Yes.
Q. On this test a person is asked questions and get points for correct answers, right?
A. Yes.
Q. And if a person says "I don't know", he gets zero points, right?
A. That's right.
Q. And if a person purposefully gives a wrong answer he gets zero points, right?
A. Correct.
Q. So if he gets lots of he zeros he gets a bad score on the test, right?
A. That's correct.
Q. And the test does not include a measure for malingering, right?
A. Not at all.
Q. So for instance, one of the questions is what year is it, right?
A. Right.
Q. And a person who says "I don't know" gets no point, rights?

A. That's correct.
Q. And the person who says 1920 when it's 2012 gets zero points, right?
A. That's correct.
Q. Another question is "what state are we in"?
A. Right.
Q. A person who says "I don't know" gets no points?
A. Right.
Q. You say the wrong state you get no points?
A. Right.
Q. So a defendant who wants to appear cognitively impaired or mentally ill can purposely giving wrong answers?
A. Absolutely.
Q. Then he would get a low score.
A. That's right.
Q. Let's talk about some of the defendant's specific responses. You asked the defendant questions about where he was at the time of the interview, right?
A. Yes.
Q. And in response he indicated he could not give the name of the prison facility, right?
A. Yes, that's right.
Q. And he indicated did not know New York City was in New York state, right?
A. Right.

Q. He indicated he had no idea he was in the United States, right?

A. Not exactly. I think I gave the actual quote. He was confused about whether New York was in -- he started talking about being in England and then I was -- he then got confused about whether New York was in the -- I said, well, you said you are in New York and New York is in the United States. He said no, no. I am -- we're in England. I said, how could we be in England if New York is in the United States? And he just got -- he said I don't know, whatever. He stopped answering at that point and he didn't actually say. I may have mischaracterized in my report. He didn't actually say we are -- oh, we are in England as an answer to where New York was.

Q. Okay. In your treating many patients with major depressive disorder with psychotic features, is it common for patients not to be able to identify whether or not New York is in England?

A. Absolutely, right. It would be completely unusual.

Q. Okay. So I'd like to play a few phone calls, if we may. If we could go to January 29 at 6:16. And the transcript of this call is Government Exhibit 27 and the excerpt that I'd like to play starts on page 4 at line 33. This is also a call between the defendant and his wife.

(Audiotape played)

BY MS. KOVNER:

Q. By the way, do you know if North Carolina is about ten hours away from New York?

A. Do I know that?

Q. Yeah.

A. Sounds about right.

MS. KOVNER: If we could play another excerpt from this call, page 5 line 7.

(Audiotape played)

MS. KOVNER: If I could play one more excerpt. This is February 7 at 10:16 a.m. the transcript is Government Exhibit 9 and the excerpt I am going to play begins on page two, line 17 and this call is not with his wife. It's with a person named Joseph.

THE COURT: Is it Government Exhibit 9?

MS. KOVNER: Yes.

THE COURT: Page two?

MS. KOVNER: Yes. Begins at line 17.

(Audiotape played)

BY MS. KOVNER:

Q. Fair to say that the awareness of the defendant's location that he displayed in those calls is not consistent with a level of awareness he displayed of his location in his interviews with you?

A. Well, the call with Joseph he seemed to be reading his address. So it wasn't clear. I agree with the first one

though, the ten hours North Carolina was.

Q. You reviewed some of the defendant's Arabic language calls?

A. Yes, the translations, yes.

Q. If I could approach, I am handing you a copy of Government Exhibit 26 and let me just direct you to page 3 of this exhibit, to the last two responses from Mr. Bejaoui on that page. And then going over to the additional discussion of Mr. Bejaoui's location on the next page. Fair to say in that call, again, he knows where he is?

A. No. It's fair to stay that he has a card with the address. He is reading his friend his name. It does not indicate that he knows where he is.

Q. Okay. Well, then let's look at one more Arabic translation. This is Government Exhibit 27 and if you could start with maybe the last two paragraphs on that first page of the call second page of the exhibit.

A. Okay.

Q. Fair to say that in this exchange Mr. Bejaoui appeared to know where he is in and when he got there?

A. About being in North Carolina again?

Q. Yes.

A. Yeah, it looks like that, yeah.

Q. Now, on the mini mental status exam you asked the defendant the season, right?

A. Right.

Q. And what was his response?
A. The way that exchange worked was, is that he wouldn't tell me the month. In fact, I said, well, could you give me -- I said, I kept saying "come on guess". No. I refuse. I am not. I don't know. I have no idea. How about the season? And it took a long, please, I am just trying to when -- I kept saying to him, I am just trying to do this assessment. I am trying to get some understanding. It's okay if you get it wrong. I had to prompt him tremendously and try to get through what I felt to be whether it was paranoia and anxiety to finally he got it wrong. He said it was I guess winter. It was totally wrong. It was March I think he said.
Q. So he told us it was winter when it was spring?
A. That's right.
Q. And --
A. My only other point was it was simple that he just -- somebody might have said, he might have come out with the wrong season. It was like pulling teeth to get him to volunteer something which ended up being the wrong season. This is a way to characterize. So this is one of the reasons why I think that a lot of these interchanges -- it's not simply there is something going on here whether it's paranoia, whether it's embarrassment, whether it's something that colors the interactions that I think has something to do with the way he is reporting. And you are right. This is not consistent with

a pure cognitive impairment that you would get by just giving the mini mental status exam to someone. So I am agreeing that those are not consistent but these interactions show there is something else going on.

Q. In fact on page thirteen of your report you wrote that the defendant was unable or unwilling to state either the year or the season or date, right?

A. That's correct.

Q. And the distinction of whether he is unable or unwilling to do those things is an important one, right?

A. Absolutely.

Q. Important as to whether he is competent to stand trial, right?

A. That's right.

Q. To be clear, on this exam, on the mini mental status exam he got zero points for all his answers?

A. For a section.

Q. Zero points for month and the day of week?

A. Right.

Q. And the season?

A. Yeah.

MS. KOVNER: If we could play February 10, 5:47 p.m. and that transcript a Government Exhibit 1A and we'll play on page 4 line 19.

(Audiotape played)

BY MS. KOVNER:

Q. Now, when the defendant talks about having been incarcerated for four years in May, in that call are you aware of whether that's correct or not?

A. I don't know if it's exactly correct, so it's probably in the right ballpark.

MS. KOVNER: If we could play one more excerpt. This is February 17, 2012.

THE COURT: How do you account for his precise knowledge? He doesn't have an address in front of him or date or calendar in front of him. How do you account for his very specific knowledge of day of how long he's been incarcerated? If you can't, you can't.

THE WITNESS: I can't. He knows it. I mean I don't know. I also don't -- I didn't ask him. I don't have a comparison, meaning I didn't say how long have you been incarcerate? I don't know how long he would have given. I don't know what to make of that. But you are right. He clearly appears to know that.

MS. KOVNER: If we could play --

MR. DRATEL: Give us the dates.

MS. KOVNER: Sure. That call was February 10 at 5:47 p.m. and this next call is going to be February 17 at 7:55 p.m.

MR. DRATEL: Exhibit?

MS. KOVNER: Government Exhibit 15, the one we're

going to play, the prior, was Government Exhibit 12. The part we are going to play is page 5 starting at line 29.

(Audiotape played)

BY MS. KOVNER:

Q. In that call he references the month of February not being over yet and this a call on February 17?

A. Yes. He seems to know the time of year that time.

Q. So the understanding of time that he displays in the call is not consistent with the understanding he shows you?

A. Correct.

THE COURT: Again, what is your explanation or --

THE WITNESS: My explanation for much of this is the context. That being in an exam where I am trying to test him as a doctor who he has ideas about why I am there and he is uncooperative for some reason whether he is holding back because he has some delusional reason to do that or, again, I understand why malingering has to be a possibility. But I think there are other possibilities, whether it's anxiety or delusionality or whatever but what it shows is that when doctors ask him these questions he does very poorly. It's been true for every single health doctor or mental care professional who's done any evaluation with him at any of the facilities have all had exactly the same interactions, type of interactions. But it is true that in these phone calls when it is someone he trusts like his wife or Riatt he clearly is able

to show that he knows what is going on. That is true.
Q. One or two more questions about this exam. So you requested the defendant to write a sentence with a subject and a verb, right?
A. That's right.
Q. And how did the defendant respond when he is asked to do this?
A. I think he had -- it took three or four tries for him to be able but he eventually did.
Q. You were sort of -- sentence that, ultimately, didn't make sense, right?
A. It had something to do with his, I am in a lot of pain or something like that but not written that well.
Q. Do you know how many points you gave the defendant for his response?
A. I think I gave him the full amount. I don't remember. It's in my report.
Q. It's all right. Don't worry about it?
A. Okay.
Q. You know the defendant speaks four languages, right?
A. I've heard that. I haven't seen it. I know I've heard him speak Arabic and I know he speaks English so.
Q. You've also read that he graduated from college?
A. Yes.
Q. Are you aware that the defendant regularly sent letters to

his wife?

A. In addition to the phone calls, yes.

Q. And are you aware that he executed a power of attorney while he was in jail?

A. Yes.

Q. The mini mental status exam also tests a defendant's ability to follow simple commands, right?

A. Yes.

Q. And I told the defendant to raise his hand as part of the exam, right?

A. Well, first I told him to actually close his eyes which is the standard instruction and, actually, I thought that as I think I pointed out in my report it's very notable that he refused to do that because he felt if he closed his eyes I might attack him. So, again, I think that was a very apt demonstration of how his paranoia and other psychopathology is distorting the mini mal. I ended up having to use, raise your hand, I made that one up off the top of my head. I've never, never had a patient when I've said "close our eyes" refused to do that.

Q. So both of those responses, fair to say, unusual for somebody with major depressive disorder with psychotic features, right?

A. Right.

Q. And you mentioned a moment ago that the first command you

gave him was to close your eyes, right?
A. That's right.
Q. And your said he wouldn't do it. You said in substance he wouldn't do it because he was afraid of doctors, right?
A. He was afraid of me.
Q. Afraid of you, right. And you attributed that to fear of doctors?
A. I don't know exactly why he is afraid. Again, it's very difficult to get him to describe the details about what's going on in his head. I do -- first of all, he just -- I said close your eyes. He kept shaking his head. No. I don't know. It took a while just to figure out. I said would you tell me why and while the silence, tell me why, just being very patient and eventually he shared with me it's because he was afraid I would hurt him and I say, okay. Let's try it. Somewhere arm that point he wanted to stop the interview and --
Q. The reason that you believed the defendant refused to close his eyes is because he was afraid of you because that's the explanation the defendant gave, right?
A. And also my clinical impression, my interaction and the way his affect looked and the way his facial expressions looked. It was not simply based on what he said. It was a clinical judgment and my interactions.
Q. Based on your observation of him you found his explanation credible?

A. Right. But I also -- I already had a hunch of that before he gave his explanation. I felt that that's what was going on. That's the explanation simply.

THE COURT: Is this a logical time to break for lunch?

MS. KOVNER: Yes, your Honor.

THE COURT: We'll pick it up again at 2:30. Thank you.

(Luncheon Recess)

AFTERNOON SESSION

2:30 p.m.

THE COURT: Please be seated.

We'll continue with the cross-examination of this witness.

My clerk as informed me that one of the lawyers called to ask if we were going over to tomorrow. That certainly was my intention if we don't finish today. If anyone can't do it, let me know. Obviously, I prefer that we finish today. I realize I did a fair amount of the questioning which probably extended the time from what was estimated but let's continue to be as efficient as or start being as efficient as we can.

MS. KOVNER: Thank you, your Honor.

BY MS. KOVNER:

Q. So, when we left off we were talking about some of the exams that you gave. I want to move now to the Georgia core competency test.

A. Yes.
Q. This test consists of a series of questions about court procedure?
A. Yes.
Q. And if a defendant purposely gives wrong answers on this test he gets a low score, right?
A. Correct.
Q. And in a sense he flunks the test, right?
A. Correct.
Q. When you administered this test you asked the defendant, for example, what the judge does during a trial, right?
A. That's right.
Q. And how did he respond?
A. How did he respond? He responded he didn't know.
Q. And you asked what the jury does in the trial, right?
A. Right.
Q. And how did he respond, right?
A. He didn't know.
Q. Now, this test does not include a measure for malingering, right?
A. That's correct.
Q. Do you know whether there are tests of core competence it that have no malingering component?
A. No, I don't know that.
Q. Let's talk about some of the specific answers that

Mr. Bejaoui gave on this test.

A. Sure.

Q. You wrote in your report when you gave the test the defendant had trouble identifying his attorneys, right?

A. Who their names were, you mean?

Q. Yes.

A. Yes.

Q. For instance, he gave the wrong name for Mr. Dratel, then you wrote that after much effort he triumphantly recalled the first name of his other attorney?

A. That's right.

MS. KOVNER: I'd like to play a couple calls. The first call is February 22nd at 1:03 p.m. and it's Government Exhibit 16. And the excerpt that I am going to play starts on page two, line 38.

(Audiotape played)

MS. KOVNER: If I could play one more excerpt, this call is March 12, 2012 it's at 5:26 p.m. and the transcript is Government Exhibit 23. The excerpt is on page five, starting at line 18. I think this excerpt, a little -- the audio volume is not great.

(Audiotape played)

Q. Fair to say that in those calls Mr. Bejaoui is correctly giving the name of his, first name of his lawyer Lindsey?

A. Yes.

Q. And he's referring to a power that the lawyers actually have, the power to compel witnesses to court in that last call?
A. Yes.
Q. And by the way you asked the defendant when you interviewed him about how he could contact his attorneys, right?
A. Right.
Q. And you said the defendant told you he now depends on lawyers coming to visit him in response, right?
A. Cause he had lost their -- he had a piece of paper with their number on it and he said he had lost it, yes.
Q. He indicated to you that you now depend on the lawyers coming to visit him, right?
A. That is what he said, yes.
Q. Now, as part of Georgia core competency test you asked the defendant about the charges against him?
A. Yes.
Q. You wrote in your report with respect to the understanding of the charges against him he has no understanding of the charges, right?
A. That's correct.
Q. And you wrote that when asked about his charges all he can discuss are the charges of sexual harassment?
A. Correct.
Q. And after you explained the charges in this case you said he had no recollection, whatsoever, of being charged with

insurance fraud, right?

A. That's correct.

MS. KOVNER: If we could play February 9th at 7:48 p.m. and the transcript is Government Exhibit 11 and the excerpt is going to be from page 6, line 22.

THE COURT: Just a moment.

(Pause)

THE COURT: Go ahead.

(Audiotape played)

BY MS. KOVNER:

Q. Now, the defendant use the word "fraud."

MR. DRATEL: Can we go to the next paragraph?

THE COURT: Yes.

MS. KOVNER: Your Honor, I'd ask that he do it on cross.

THE COURT: I take it your argument is that it's incomplete without that paragraph, sir. Mr. Dratel, is that your argument?

MR. DRATEL: Yes. Most of the stuff I'll do on cross because they appear on different pages. This one is the next paragraph.

MS. KOVNER: It may take us a moment to queue that up.

THE COURT: I understand. Just let me look at it before I rule on it.

(Pause)

THE COURT: All right. Mr. Dratel, you've read that paragraph, the one as on page 4, line 7?

MR. DRATEL: Yes.

THE COURT: Is there anything in particular I need to hear about the tone?

MR. DRATEL: No, your Honor.

THE COURT: All right. I've read that.

Proceed, Ms. Kovner.

BY MS. KOVNER:

Q. Dr. First, the defendant used the word "fraud" in this conversation with his being moved to a federal place. When you asked him about the charges against him he didn't use that word, right?

A. No.

Q. In fact, he talked about sexual harassment, right?

A. That's correct.

Q. Did you confront him with that inconsistency?

MR. DRATEL: Objection, your Honor, as to form.

THE COURT: I'll sustain it as to form.

But did you point that out to him?

THE WITNESS: My -- when I discussed the charges I always discussed it in terms of "insurance fraud", not just the word "fraud". So I guess, technically, you could say that they used the word "fraud" out of context of what -- in fact, it's a complicated issue of the insurance law. Whenever I talked to

him about insurance he talks to me about, yes, I've brought insurance. I have car insurance. I have auto insurance. When you put the word "insurance" fraud which is the actual charge he doesn't understand that. I've never independently said, oh, well, on the one phone call you use the word "fraud". I've never actually said that. But whenever I've discussed the charge of insurance fraud he says he has no idea what I'm talking about. I don't remember that.

Q. You didn't regard this call as creating a discrepancy or an inconsistency that was worth addressing with him?

A. No.

Q. Let's talk about the third test that you gave. Was it impression screening test?

A. It's not a screening test. It's a test of symptoms for depression.

Q. Let me hand you what's been marked as Government Exhibit 41 for identification. Is that the test you filled out?

A. Yes, it is.

MS. KOVNER: Your Honor, the government offers Exhibit 41.

MR. DRATEL: No objection, your Honor.

THE COURT: 41 admitted. Could you give me a copy of it. The book I think only goes up to 39.

(Government's Exhibit 41 received in evidence)

MS. KOVNER: Your Honor, I think we got this last

night, so it wasn't included in the material.

THE COURT: I don't mind. I just need a copy. 41 admitted.

BY MS. KOVNER:

Q. This is two pages, right?

A. That's right.

Q. And it does not include a malingering screening mechanism, right?

A. That's correct.

Q. So the score that you calculate in this it's based on the defendant's self-reporting, right?

A. No. It's not a self-report test at all. It's a clinician administered test, so it's based upon my clinical judgment of the presence of, absence of the symptoms based on his self-report and my observation.

Q. So --

MS. KOVNER: Excuse me one moment.

(Pause)

BY MS. KOVNER:

Q. If you could just help to understand then, for instance, on the first question which refers to sleep and onset of insomnia?

A. Yes.

Q. You gave the defendant two points on that question because he takes at least 30 minutes to fall asleep more than -- and I apologize -- more than some proportion of the time?

A. That's right.
Q. Hard for me to read exactly what proportion. When you scored that as two points was that based on the defendant's self-report to you or based on something else?
A. That was based upon his description of his sleep pattern which I interpreted as that score. It does not come from any observation by anyone else, that is correct.
Q. Are there other questions here that you answered based on something other than his self-report?
A. The psychomotor retardation.
Q. Any others?
A. The item about depressed mood is also based on how he looked and his demeanor during the exam.
Q. Did you credit all of the defendant's responses when he answered the screening questions you asked with respect to this test?
A. Did I what?
Q. Did you credit them? Did you believe them?
A. Yes.
Q. Let me direct your attention to the 12 questions of suicidal ideation.
A. Yes.
Q. And you gave the defendant three points for thinking about suicide and death several times a day, is that right?
A. That's right.

Q. But you didn't recommend that the defendant be placed on suicide watch, right?
A. That is correct.
Q. On your direct you described the defendant as not suicidal, correct?
A. That's correct.
Q. You testified that you developed a, I think more detailed screening test, the SCID test, correct?
A. It's a test -- it's an interview which covers all psychiatric diagnosis, that's correct. That's correct, the many or most of the major psychiatric diagnosis contained in the diagnostic manual.
Q. And you didn't formally go through that test with Mr. Bejaoui?
A. That's correct.
Q. But you said you asked many questions parallel to the SCID that he'd internalized?
A. Also used the structure of the diagnostic logic in the SCID.
Q. Did you write in your notes of your meetings with Mr. Bejaoui the meaning of the questions that you asked?
A. No. My notes were his answers.
Q. Did you write all of his answers in your notes?
A. As best as I could while paying attention to him and writing things down.

Q. The fact that you didn't write the questions that elicited those responses makes it harder for somebody else to assess the data that you produced, right?
A. Yes, that's true.
Q. You were aware in this case that malingering was a significant diagnostic issue, right?
A. Right. Yes.
Q. You were aware that a prior evaluator had concluded the defendant's malingering at Butner?
A. Yes.
Q. Are you aware that Dr. Channel had concluded that and ruled out diagnosis?
A. Yes.
Q. You were aware that the three tests we just described are tests the defendant could deliberately flunk, right?
A. Yes, I am aware of that.
Q. Now you testified on your direct that you are aware of tests for malingering, right?
A. That's right.
Q. And you said you didn't give those tests because you were following the lead of Butner, right?
A. Yes.
Q. Are you aware of whether or not the defendant was willing to cooperate with evaluators at his prior facilities when they tried to give him tests?

A. According to the notes at Butner that said he is not cooperative.

Q. Now, let's turn to some other ways of detecting malingering. You testified -- well, let me -- not certain but would you agree that differences in how an individual presents when he notices he is being observed versus when he doesn't know are relevant to whether the defendant is malingering?

A. Yes.

Q. And when you listen to the defendant's prison calls in this case you thought they provided evidence he was not malingering, right?

A. It provided mixed evidence. I think it provided evidence that his presentation during the mini exam was exaggerated and also provided that he is not malingering psychotic episodes that someone can have psychotic symptoms and be competent.

Q. Right?

A. Yes.

Q. One of the calls you relied on in concluding that malingering did not explain all of the defendant's symptoms was a call where the defendant talked about his wife coming to court, right?

A. Yes.

Q. Saying that he couldn't understand what was going on in court, right?

A. Right.

Q. Are you aware that the defendant made a call after he had been advised that he sounded different on his phone calls?
A. He made that call about two months afterwards, so yes.
Q. Are you aware that the defendant by the time of his phone call --
MR. DRATEL: Object to "aware" in the sense of generally aware. Did he -- did Dr. First inform him of that?
THE COURT: No, I'll allow that. "Did you know", that's fine.
Q. In fact you specifically informed him that he sounded fine on his phone calls, right?
A. During one session with him I pointed that out to him, yes?
THE COURT: That's prior to the phone call that Ms. Kovner is referring to now?
THE WITNESS: During my direct I did -- I talked about a phone call that is made, just a few in July. There were other -- I mean if you want, there are other, many other times during, before, during the calls from Butner and Devens where he said over and over again, I don't understand things. He didn't understand to -- he needed explanation. Before I --
Q. You mentioned this call on your direct?
A. Yes. Based upon that call, that call did occur after my interaction with him in which I pointed out the interactions with him, that's correct.
Q. You pointed out in rejecting the diagnosis of malingering

from Butner that the defendant expressed delusions on some calls, right?

A. Yes.

Q. And in other words, you believe he displayed genuine mental illness on those calls?

A. That is correct.

Q. Fair to say that genuinely mental ill defendants can feign incompetence?

A. They can.

Q. I am going to turn to some of the other considerations you relied on in making your diagnosis. In diagnosing Mr. Bejaoui you relied in part on information about his past mental health history that was provided by his wife, correct?

A. That's correct.

Q. And I think on your direct this morning you testified that Mrs.~Bejaoui provided a fairly convincing history with regards to her husband, correct?

A. I was convinced, yes.

Q. And you said on your direct that the most interesting part of that history she provided was his history of paranoid -- writing a little hard to read but -- idealization?

A. Ideation.

THE COURT: Ideation.

Q. And in your report you described it as quote, particularly noteworthy, unquote, that the defendant had a premorbid history

reported by his wife of episodes of paranoia in which he felt that people were watching him and following him, correct?

A. Yes.

Q. You knew that Mrs. Bejaoui had been interviewed on multiple occasions before you interviewed her, right?

A. Yes.

Q. Are you aware that Mrs.~Bejaoui had told Dr. Channel her husband had never had a significant history of mental health problems?

A. I don't know what -- I didn't see the notes of her phone call with Dr. Channel, so I don't know what questions he asked her.

Q. Were you aware that that was what Dr. Channel reported in his report?

A. I am aware that Dr. Channel said that, yes.

Q. Are you aware that she wrote a letter to the Court -- let me --Are you aware that she wrote a letter to the Court in which she said that Mondher entered the prison perfectly healthy and now requires 11 narcotic medications?

A. Yes.

Q. Did you ask Ms. Bejaoui about why she had not apparently reported these problems to the prior evaluators?

A. I'll have to look through the record. It is my impression in the Butner record there was an acknowledgment that he had treatment for depression and anxiety. I am not the first

person that uncovered that, so I am sure of that. I don't know if it was Dr. Channel's report or in the Butner report but when I spoke to her the part that I found from her that I had not seen else where was the psychotic symptoms. But the issues of his depression anxiety and phobias, I read that in a couple reports done by other people. So I'm not the first person to come up with that.

Q. Yes, but focusing a moment on the paranoid symptom that wasn't reported elsewhere, right?

A. That's true.

Q. And you didn't confront her with that lack of prior reporting, right?

A. No, I did not.

Q. Did you identify in your review of material in this case any evidence that Mr. Bejaoui had coached Mrs.~Bejaoui on what to say?

A. Coached her what to say to whom?

Q. To evaluators.

A. I am sure you'll show me what -- there's something --

THE COURT: Don't worry about what's next. The question is simply --

THE WITNESS: I do remember there's some statement where he told her to be -- I don't know what he said. He did talk to her about "when you speak to doctors" or something. I don't remember what the content was. But I do remember in all

of the review of all the case there was some interchange between her and him about when you are speaking to the doctors for Butner or Devens but I don't remember what it was.

Q. Now, another factor that you placed some emphasis on in your report is the fact that a reported fact that the defendant had a schizophrenic brother, right?

A. Tiny evidence, tiny emphasis but, yes, I feel that noteworthy but I agree we have no corroborating information on that.

Q. I'll be specific about it. On page 16 you say that the history of symptoms -- do you have your report?

A. Yes.

Q. It's at the very top and the sentence starts on the prior page but you are discussing how he would begin to have this condition and you say, the history of such symptoms is that the wife was reporting coupled with the reported family history of a -- relative i.e. his brother's schizophrenia might explain why Mr. Bejaoui would have developed psychotic symptoms in a stressful environment such as incarceration.

A. Correct.

Q. But you testified about that evidence as contributing to your diagnosis on direct as well, right?

A. Exactly.

Q. Now, the evidence supporting the conclusion that Mr. Bejaoui had a schizophrenic brother is Mr. Bejaoui's own

statements, right?

A. That's right.

Q. And those statements are summarized on page two of your report in the first full paragraph on page two?

A. Yes.

THE COURT: Is there any correlation in the medical evidence between a sibling with schizophrenia and a sibling with major depressive disorder with psychotic aspects?

THE WITNESS: Yes. There is -- it's turned out that even though people with schizophrenic relative are at higher risk of developing a major depressive disorder with psychotic features as well as the other rule out diagnosis which is schizo effect disorder and as well as bipolar disorder. So there is some risk when you have a schizophrenic relative.

THE COURT: In siblings?

THE WITNESS: Yes.

THE COURT: But it's only his report. You don't have any independent knowledge about his brother's situation?

THE WITNESS: No.

Q. Are you aware that you only one of four evaluators who interviewed Mr. Bejaoui to whom he reported that his brother had schizophrenia?

A. I believe there was another report that said he had a brother, a sibling with I thought major mental illness. There was some question of a sibling being hospital -- I was the

first person who was able to actually get this specific report of the story with the medication and he was institutionalized back in Tunizia. But I believe there's another report somewhere that came up as a suggestion to when I saw it I said, ah-hah this actually fits with what I had read before. I remember what I saw which is like oh, it isn't the first time I'd seen this. This echoes something so that some other evaluator got in a different form that was less detailed.

Q. It was your impression in this report that what Mr. Bejaoui gave you was consistent?

A. At least a report made to one other person.

Q. You knew that Mr. Bejaoui told lies about his family, correct?

A. Yes. Lot of confusion, so I assume some of it's lies, yes.

Q. For instance, when you -- we can take a specific example in this paragraph where you recounted the brother had schizophrenia. In the sentence before that one you recounted the defendant as saying his mother had died in childbirth, right?

A. Right.

Q. And you were aware that Mrs.~Bejaoui had explained that the defendant had been married to her when his mother died, right?

A. Actually, when I spoke to her she was confused. She said she's confused about whether this person who raised him for, the aunt or the mother, so there's confusion on her part. She

says, well, this is what I know and I don't know what the real truth is. So she -- there's confusion about that.

Q. Were you aware that according to the Butner report she had told the Butner evaluator that the defendant's mother had died during the period they were married?

A. I don't recall that.

Q. The next sentence in this family history paragraph describes the defendant having experienced repeated physical abuse at the hands of his father, right?

A. According to him, yes.

Q. Were you aware that at least some of the reports of his abuse were made up, right?

MR. DRATEL: Objection.

THE WITNESS: No, I am not aware of that.

THE COURT: Just a moment.

THE WITNESS: Are you referring --

THE COURT: Just a moment, sir. I will allow that. The answer is he is not aware of it. Next question.

Q. Some of the things the defendant said to evaluators that were not true included convincing details, right?

A. Including what?

Q. Convincing details, right?

A. I am not sure what you are referring to.

Q. Let me give a specific example. The defendant described under ECT, right?

A. In the phone calls, yes.

MR. DRATEL: Objection. In what context on the phone.

THE WITNESS: Actually, no, I don't know.

THE COURT: I'll allow it. Did the defendant ever describe undergoing electroconvulsive therapy.

THE WITNESS: Not exactly what he was talking about the idea about -- okay. He said, no, he did -- at one point he said in Manhattan he had gotten another -- he implied a Devens ECT. That's true.

Q. The account of ECT that he gave was so detailed that it ma made you think that, perhaps, it happened at Butner, correct?

A. No. He actually was -- I believe he was implying that it happened at Devens. And another point to another person on the phone calls he said it happened in Manhattan. So what I, actually, thought was he was confused that it may have happened at Rikers. But since we didn't have the records at Rikers it was an open question. But I thought it was more than possibly that ECT because we know that there's a psychiatric history at Rikers for which the records weren't available.

Q. Let me break this up a little bit. You found the account of ECT sufficiently compelling that you thought he may have received a ECT?

A. Absolutely.

Q. Did you see any evidence in the medical records you reviewed that he had received ECT?

A. No. Neither Butner or Devens, none, no.

THE COURT: And you had none for Rikers?

THE WITNESS: None for Rikers.

Q. Now, one of the reasons that you rejected the conclusion of malingering that the evaluators at Butner drew was that you found that there wasn't an external motive that would explain the malingering, right?

A. Certainly. Again, the word "malingering" is confusing because apparently the claim at Butner is he has malingered in many different things, including the wheelchair use, the pain, the disability, so --

Q. Let me then -- let me narrow it. One reason you rejected the conclusion that he was, in fact, competent to stand trial but was pretending not to be was that you couldn't find external motives that was plausible and could explain it, right?

A. Exactly. It would explain this specific aspect of the malingering.

Q. For example, you were on page 17 in the evaluation from FMC Butner, no evidence or even hypotheses are offered to see what possible motivation Mr. Bejaoui might have had or feigning his physical, psychological symptoms to the point where he would be rendered indefinitely incompetent for trial and sent to a facility hundreds of miles away from his friends and family for months on end in order to be evaluated and restored to

competency. He has already served more time in detention than he would face in sentencing, a fact that his attorneys and his wife have attempted to communicate with Mr. Bejaoui but to no avail, right?

A. Yes.

Q. If the defendant did have an external motive to malinger and to malinger in this particular way, that would be a relevant analysis of whether Butner conclusion was correct, right?

A. There was a clear motive that would be clearly relevant.

Q. That motive would make it more likely that the defendant's pain -- and generally being incompetent?

A. Depends on the clarity of the motive, yes.

Q. Sufficiently clear motive?

A. If there was like, for instance, let's say a hypothetically I discovered that there was evidence he had killed somebody and he was running from the law and it was safer to be in the prison, something like that, I could imagine a circumstance where you could concoct a scenario where it might have made sense for him to be malingering. It would be better for him to be where he is now than to be out.

Q. But didn't see motive like that in this case?

A. No.

Q. And that was a factor?

A. That is correct.

MS. KOVNER: No further questions.

THE COURT: Thank you. Any redirect?

MR. DRATEL: Thank you, your Honor.

THE COURT: Is the government postulating a motive for malingering? What's the government's theory for a motive for a malingering?

MS. KOVNER: Your Honor, I think there are several. I think the immigration motive is present here. The defendant has been told in court in proceedings during which he appeared fully engaged that deportation is a likely consequence of a felony conviction.

THE COURT: When was that? In this case? In U.S. versus Bejaoui here?

MS. KOVNER: Yes, your Honor. We had a bail proceeding before you. This was early on in the case when Mr. Bejaoui was quite engaged. And one of our principle arguments for detaining the defendant was this is a defendant who's likely to be deported upon completion of his sentence. And he discusses immigration in phone calls both with his wife and with others. This is something that's on his mind, I think for a good reason if he is a person who's been here for a long time and will be deported to Tunizia. So I think that's the principle motive. I also think the --

THE COURT: Although, one can question whether somebody in that mine would rather be in a federal medical

facility than opposing deportation.

MS. KOVNER: I imagine it would differ from individual to individual depending where you are going back to what your relationship is to that country.

THE COURT: Is there anything else?

MS. KOVNER: Yes, your Honor. The defendant is charged with a serious fraud. The loss amount in this case is significant. I think the idea that the defendant will inevitably receive a sentence of time-served were he to go to trial and be convicted or enter a plea of guilty. I don't think that's inevitable. It's certainly something that there is no promise about up front. So I do think a defendant could reasonably be afraid of what sentence he would receive.

MR. WILSON: If I could just add one point?

THE COURT: I don't know about double teaming, but go ahead.

MR. WILSON: Just because we were so far apart. The one point I would just add is the defendant may very well not expect to be in a prison hospital forever. He will hope that this case will ultimately be dismissed on a number of grounds available. Then he will spend a short time in federal prison versus a lifetime in Tunizia.

THE COURT: All right. Thank you. Redirect?

REDIRECT EXAMINATION

BY MR. DRATEL:

Q. Doctor, given your expertise go back to the beginning in terms of forensics, do you feel that -- do you feel qualified that make a diagnosis and report in this case?

A. Yes, I do.

THE COURT: Your report concludes, if I remember correctly, that within a reasonable degree of medical certainty -- let me get the exact words -- that Mr. Bejaoui's disorder, mental disorder, namely, his major depressive disorder with psychotic features grossly interferes with his ability to understand the nature and consequences of legal proceedings before him or to properly assist in his defense, using the definition that we start off with and thus he is not currently competent to stand trial. Can you give a number to the percentage to the reasonable degree of medal certainty with which you've reached your conclusion.

THE WITNESS: First of all, with respect to the actual statement itself there are two components, the ability to understand the nature and consequence of legal proceedings and to properly --

THE COURT: "Or".

THE WITNESS: Or to properly assist. My belief all along is that to properly assist in the defense which has been that's the reason why his attorneys sought the help of a psychiatrist in the first place. It became impossible to work and completely impossible to provide any assistance in his

defense and I believe that that is a direct result of his mental disorder. So I would say that -- I would say within 70, 80 percent, certainly, that this is true with that component.

THE COURT: Properly assist in his defense?

THE WITNESS: Yes.

THE COURT: What about the other --

THE WITNESS: The ability to understand is, I feel, a little less confident because of the -- that's where the confusion about the phone calls makes a little bit more unclear. And I agree that some of the statements in which he talked he seems to understand some aspects of legal proceedings. At least in the phone calls at that moment in time it does raise a question about what his understanding is at other times. One can, certainly, have his in the same way he does not do well dealing with physicians and other healthcare professionals, he doesn't interact well with the lawyers either. I have a suspicion. We have that actually on the tapes where he feels that his lawyers are lying to him. I think some of the paranoia that applies to the doctors also apply to those lawyers. So I think there's similar interactional problem and he seems to fall apart in dealing with the lawyers.

So whether it's -- how much of it's an inability to understand the proceeding versus that gets played out when he deals with his lawyers more so than when he speaks to his wife

or his friend on the telephone but -- so it's a little cloudy to what he actually understands given to the confusion. But I have very little doubt about his inability to properly assist in his defense

THE COURT: Thank you.

MR. DRATEL: Thank you, your Honor.

Q. With respect to the tests you went through and Ms. Kovner took you through some of the test and with respect to the malingering you pointed out earlier that Butner didn't do any malingering tests, right?

A. That's right.

Q. And they didn't do any of the other tests that you did perform, right?

A. That's right.

Q. I want to talk to you about some of these telephone calls that were -- if you -- do you have it in front of you?

A. I don't have any copy. I don't have page numbers on it.

Q. I'll try to -- do you have my Government Exhibit number?

A. I have my own copy. I have the one that I just got from the state yesterday.

Q. Let's try March 3rd at 5:41.

THE COURT: Do you have a Government Exhibit?

MR. DRATEL: I think it's Government Exhibit 19, I believe.

THE WITNESS: March 3, 5:41, what page?

BY MR. DRATEL:

Q. Okay. You were asked, this is where he spells Dr. Herbel's name.

A. I see that, yes.

Q. At pages two?

A. Three and four.

Q. You were asked about that and that was played for you. Let's look at page three, in that large paragraph in the middle of the page.

A. Yes.

Q. And could you read that one for us? We'll save time if you could read that one for us.

A. Sure. One, two, three, four, five. That way you can save it. You know what to do with the paper that has --

THE COURT: Where are you?

THE WITNESS: Line 11.

THE COURT: Yes, I see.

THE WITNESS: It has everything from the day they lie about me but I can't read them Maria. I don't know how to concentrate any more. I can't think and I think they are going to do something to me. The other thing I want tell you about and I want you to please remember it. They are trying to take -- they claim they are going to take me to MRI. They were not taking me to MRI. I know what they are going to do. They are going to drug me like they did in Manhattan and they are

going to give me something called electrical current, electrical current. Okay. I am it now, electrical compulsive shocks. They are going to try to agitate my brain so they are going to make me like the other one they did in Manhattan. One week and I couldn't even remember my name. One week and I couldn't remember my own name they. Were trying to do it here. The doctors speak to you. He lied to me. He told me no. You go for MRI. Bullshit. He's not taking me MRI. They are taking me for something call ECT. They are going to shock my brain with electrodes. This is going to happen to me sometime. I am going to refuse but in case they drug me or anything like that, if you don't hear from me this is what happened to me.

Q. Now, can you look at one part of that conversation without looking at this part of the conversation before you drew a conclusion about whether someone is suffering from a mental disorder or whether they're malingering?

A. Right. That is -- my feeling is you have to put the two together.

Q. You can't look at one just select one and draw a conclusion from that without looking at the whole?

A. Yes.

Q. And by the way, this is the conversation and the passage that you talked about earlier in a much later cross about his reference to Manhattan in the context of electro convulsive therapy?

A. Right.
Q. Is this an indication of paranoia?
A. Absolutely.
Q. And he is talking to his wife, right?
A. That's right.
Q. This is pretty heavy duty paranoia?
A. I'd say he's delusional and he is convinced this is going happen and he's frightened.
Q. Next, let's look at Government Exhibit 23. That's March 12th at 5:26 p.m.
THE COURT: Is this before you --
THE WITNESS: These are all before the time I told him.
MR. DRATEL: These are all Butner calls, your Honor.
THE COURT: It was after he left Butner?
THE WITNESS: Yes.
THE COURT: You didn't see him down at Butner. It was only after he was transferred from Devens to Butner down here?
THE WITNESS: Yes. March 1.
Q. Yes. You were asked about the immigration, right, on page two about Dr. Herbel calling about immigration status, the first paragraph?
A. Yes, I see it.
Q. OK. Look at page three, line 14. If you could read that paragraph. This is Mr. Bejaoui with his wife, right?

A. Right. I am not taking the medicine any more, not taking their medicine. They are going to poison me. I am not eating their food because they are going to poison me. The doctor said he is going to railroad me. I am scared to be here, Maria. I am scared.

Q. Can you look at one section of this call without looking at the other section and drawing a conclusion about whether Mr. Bejaoui suffers from the disorders that you diagnosed?

A. No, you can't.

Q. Then in the sense by choosing one and ignoring the other -- by choosing one and not addressing the other is kind of replicating what Butner did in its report?

MS. KOVNER: Objection.

THE COURT: Sustained.

Q. Now, let's look at Government Exhibit 7 which is January 29. There are two calls on the 29th. This is the second one at 6:16.

A. Okay.

Q. Now on page 5 that first large paragraph starting at line 7.

A. Yes.

Q. He's talking about me, right, he is talking about his lawyer visiting him?

A. Yes, that's right.

Q. He's relating a conversation that he says that we had,

right?
A. Yes.
Q. That have some elements of paranoia in it?
A. What line are we on?
Q. Line 7, on page 5 nothing, absolutely, nothing?
A. Nothing, absolutely, nothing.
Q. Is there some distrust of the lawyer in that paragraph?
A. Only his concern about, yes, his distrust of the lawyer.
Q. Okay. And the page before starting at line 33 where it says, I know because you know me from way, way before these people get into my life and ruin my life and now they're sitting there laughing at me. You are not better than me to sit there laughing at me knowing that you ruined my life. How would you interpret that in terms of his -- what does that say to you as a diagnosis?
A. Elements of paranoia also very typical. If it were my diagnosis about the psychotic features and depression with this idea you are being made fun of and laughed at has been a -- of what he talked about being laughed at and being called names.
Q. Would this exist whether or not he's actually called names or being laughed at?
A. Right. There is still no reason to believe he is being called names.
Q. February 10, 2012, I don't have the Government's Exhibit number, unfortunately, on this one.

MR. WILSON: I think it's 12.

Q. Okay. You were asked about on page 4, if you look at line 21 you were asked about May 15th that he knew the date that he -- that that date is the date that marks his first day in prison, right? You were asked about that?

A. Exactly.

Q. Let's look at page 3. I am sorry, page two line 19.

A. Right.

Q. I'll read. This is Mr. Bejaoui speaking to his wife again. I am really convinced that these people -- they wanted to kill me because of the things I know and the mathematical algorism and all that stuff. But, hey, I'll tell you, the point is a lady when she gets the phone call Monday thinks that she can tell you her husband that she doesn't understand him any more. You understand the handwriting is different. Things are very different. You follow me? Maria. No.

Now, can you separate that part of the call from another part of the call in making your evaluation as to whether or not Mr. Bejaoui suffers from some mental disorder?

A. Absolutely not. This quote here is one of the more cogent ones. Well, what he is referring to is the whole delusional system had come up around that time about mathematical algorithms. The fact that he is saying this to his wife and she has no clue what he's talking about. And this is -- he had mentioned some of this to his evaluator. And this was

dismissed as malingered psychosis because it would seem to be too bizarre and yet he is mentioning the same thing to her and she is totally perplexed about what's going on which would be very typical for somebody with a psychotic symptom to talk about it with anyone because there is really -- on his mind. So I think this is a classic example of the psychosis being recorded in a sitting where he is unaware that it's being recorded to his wife for no other possible reason that this is an experience that he is experiencing and he is having it with his wife.

Q. Okay. Now, this is before you ever met, right?

A. Yes.

Q. This is before the Butner report was ever completed, right this is February of 2012?

A. Correct.

Q. This is within roughly ten to 12 days of him arriving at Butner?

A. Yes.

Q. This is already around the time that if you need to reference on June 14 of the Butner report, this also around the time that he was discontinued on risperidol?

A. Right.

Q. Let's look also at same call on page 5 line 14 the last sentence, Mr. Bejaoui, talking to his wife February 10, 2012. I was taking pain medicine because I've always suffered from it

and I don't want people to ask me about my pain because it reminds me of my childhood. Can you look at those kinds of statements -- rather, can you look at any of the other parts without looking at the whole of the conversation?

A. No. That's a very relevant statement to understand how he thinks.

Q. Let's look at Government Exhibit 15 which is February 17 at 7:55 I think it must be p.m.

Okay. You were asked about this conversation on cross-examination, right? This is one of the ones. But if you look at page 2 line 34 and he says to his wife again at Butner. She says, how are you feeling? Line 32, line 34, his answer, so-so, not very good but it's okay because the medication makes me sometimes forget things. So I brought you an information but I wanted to confirm it. Again, can you look at a conversation in its entirety -- rather, can you look at conversation in isolation without looking at the other elements of the conversation to form a diagnostic opinion?

A. No.

Q. And does that statement to his wife support some sort of cognitive impairment?

A. Absolutely. It may be a question of it's to the extent that shows up on the mini mal test status but that, certainly, and conditions where he is not aware of being observed as evidence of a reported cognitive impairment.

Q. Now, when you do a diagnosis, when you interview a patient are you able to read his or her mind?
A. I, certainly, wish I could but I can't.
Q. Move on to Government Exhibit 16. That's February 22. Okay. You were asked about the -- that he knew it was Lindsey was his lawyer, right, or one of hits lawyers?
A. Yes.
Q. He doesn't mention that there's another lawyer as well, does he?
A. No.
Q. Primary lawyer, right?
A. Right.
Q. And I am not going to go through them with you but you mentioned in your direct and just there are other -- there are many other instances in these phone calls where he says the lady lawyer or he is unable to name her?
A. That's right. The majority of time that's the case.
Q. There are other times they call her Linda and Laura. They have a different "L" names for her. Do you recall that?
A. No. I -- actually, I'm not sure about that.
Q. Also Mrs.~Bejaoui is in contact with Lindsey, correct?
A. Yes.
Q. So she is mentioning the name as they go through these conversations as well?
A. Repeatedly, yes.

Q. Government Exhibit -- February 9, 7:48. I don't know the precise exhibit number.

MR. WILSON: 11.

MR. DRATEL: Thank you.

Q. That's the one about the fraud that he mentions fraud. We know from the Butner report that he is confronted with that by the people at Butner who said you are indicted for fraud, right?

A. Right.

Q. So he is just essentially repeating what he was told by them?

THE COURT: Try not to lead quite so much.

MR. DRATEL: All right, your Honor.

Q. Is it --

A. He certainly heard people have brought up the idea of insurance fraud many, many times. So it's possible he could be -- it back. So it's possible they said fraud. There's still no indication that he actually understands what that means.

Q. Also is it -- does that -- well, you answered that question with that. It doesn't -- I'll withdraw that question.

By the way, is there anything else in the conversations where he suggests that he does understand what that means from your recollection?

A. No, never.

Q. All right. In that same conversation where he mentioned the word fraud, let's look at page 4, line 16. He says they want to kill me, yeah, they want to kill me over here. That's what they planning to do but it's okay. You tell them whatever you now know. Whatever you know just tell them. Remember that people are not fair, you know. Then -- well, you were read that cover up and then if you look before that cover up paragraph right page 22 that was played -- I'm sorry. Page 6 line 22.

A. Yeah.

Q. That was played for you, right, they want to cover up, Maria, they want to cover up.

THE COURT: Yes, that was played.

Q. But if you look above that on line 14 there's a paragraph. And if you look at the last sentence of that Mr. Bejaoui telling his wife, I don't remember what's going on any more. I have memory issues right now that's stopping me from protecting myself. Can you look at the conversation one piece without looking at that as well?

A. No, not at all.

Q. Now your conclusions in your report and your testimony today based on two tests, the MME and the Georgia competency test.

A. Those were used in my conclusions.

Q. Is that what your conclusions are based on?

A. In part.
Q. What else are your conclusions based on?
A. Based on the clinical evaluation over five interviews, a review of all the records and among the most important elements was the tapes. I agree with the government that the tapes are very valuable as a way of being able to parcel out what, how else one presents when they are not aware of they are being looked at where shall I find the tapes very important.
Q. But would you base your conclusions solely on those tests?
A. No, not at all.
Q. And you factor into your conclusion that those tests are not malingering?
A. Exactly, yes. When I got them the MME status I, certainly, didn't believe that this was an accurate reflection of his cognitive function at the time of my interaction.
Q. Now, you were asked about looking at the Butner report and that it concluded that Mr. Bejaoui was malingering. But you also had other reports all of which were --
A. Independently --
Q. They all reached conclusions that is the same as yours?
A. That's right.
Q. Now, was there anything in the conversation since his return to MDC that changes your conclusions?
A. You mean in the more recent?
Q. Yes.

A. Material that I just got, the tapes.
Q. Yes.
A. No.
Q. Is it pretty much the same?
A. It is, yes. I think on both sides it shows that he continues to sound different on the telephone than he does to me in person and it continues to show evidence of paranoia and psychosis in the content of the calls.
Q. And you -- it's still the same two people, his wife and friend Riatt?
A. Actually, the calls are in Arabic but I assume that it is -- that's who it was.
Q. Now, is there any evidence in anything you've seen that suggests that Mr. Bejaoui coached Mrs.~Bejaoui on describing his medical history or his mental health history?
A. No. I've seen absolutely no evidence to support that contention.
Q. And if he were malingering -- withdraw that and rephrase it another way. He has been in this shape, in this condition for about 18 months now, right?
A. Yes.
Q. And about six or eight months into it, maybe even more interview by Devens she doesn't mention paranoia and being followed, right?
A. That's correct.

Q. And if she'd been coached to help with his malingering wouldn't it be logical that she would have volunteered that?
A. Yes.
MS. KOVNER: Objection.
THE COURT: Sustained. I'll disregard the answer.
Q. If someone was coaching someone to help them malinger, in your experience don't they volunteer information --
MS. KOVNER: Objection.
Q. -- at the first opportunity?
THE COURT: Just a moment. I don't know how he is capable of answering.
You may answer.
THE WITNESS: Could you repeat the question?
MR. DRATEL: Could I have it read back?
THE COURT: Yes.
(Question read back)
Q. The person who is being coached?
A. Yes, I would think so. Yes, that would be the most helpful way to do it.
Q. To --
A. To volunteer.
Q. Do you have the Devens report in front of you?
A. No, I don't.
MR. DRATEL: May I approach, your Honor?
THE COURT: Yes.

Q. Page 4 --

THE COURT: How much longer do you have?

MR. DRATEL: Not much, couple minutes. May I ask from here, your Honor?

THE COURT: Yes.

Q. On page 4 at the top of the paragraph that continues from page three we can look at page three to the bottom and see that it's an interview with Maria Bejaoui. And it says that she reported he was reportedly participating in treatment. I am sorry. Let me start again. Really covers from the previous page. However, when they met he was reportedly participating in treatment with medication and therapy for anxiety, claustrophobia, and difficulty sleeping. So that's where you got that?

A. Thank you for pointing that out. That's exactly where I got this from.

Q. Now, we talked on direct about malingering as well?

A. Yes.

Q. Is it your experience that sometimes family members, immediate family members malinger well along with the patient?

A. Absolutely. It's very stigmatizing to have a family member with mental illness to admit to that. People are often in denial about the presence of mental illness in themselves and their family. So malingering well, it can be a conspiracy of malingering well.

Q. And is it also why you ask more questions and probe history because people don't volunteer these things?

THE COURT: Sustained.

Q. In your experience is it necessary to ask questions and probe to get a accurate and complete history from family members who might otherwise be in denial?

A. Absolutely, yes.

Q. Now, you were asked about the brother, Mr. Bejaoui's brother and whether there's any evidence about the fact that that might independently corroborate what he told you?

A. That's right.

Q. Now, again, he mentioned that his brother -- he said that his brother had died from diabetes because of taking antipsychotic medication, risperidol, correct?

A. That's what he told me.

Q. That is one of the side effects, potentially?

THE COURT: Diabetes, not dying.

MR. DRATEL: Right, diabetes.

THE WITNESS: Diabetes.

Q. And if some one were malingering would the first time -- in your opinion professionally, in your experience would someone who is malingering raise this for the first time only upon being probed by the fifth or sixth or seventh or eight doctors who examined him?

MS. KOVNER: Objection.

THE COURT: I'll allow it.

THE WITNESS: Doesn't make sense. For it to come out at this point in time if somebody was willfully trying to paint a picture for themselves, that would be the kind of thing he would be consistently saying from the very beginning. As I had mentioned, to get that piece of history required a real effort on my part to try to find out why he was so reluctant to share his hearing voices and his fear of taking medication. So it was an effort to get that out. If somebody were malingering that would have been volunteered a long time ago if he was saying that simply for the purpose trying to make it look like he had an illness as well.

MR. DRATEL: Thank you. Nothing further, your Honor.

MS. KOVNER: Briefly, your Honor.

RECROSS EXAMINATION

BY MS. KOVNER:

Q. Mr. Dratel asked you a few questions about coaching. Do you recall that?

A. Yes.

Q. If there were evidence of coaching, that is, evidence that Mr. Bejaoui was coaching his wife about what answers to give to evaluators would that be relevant to an analysis of whether he's malingering?

A. Because as I mentioned earlier I have some recollection that he said something to her about when she spoke to the

doctors. I don't believe it was coaching but I guess I am willing to enter. Yes, if there was someone that was clearly coaching it could be definitely relevant.

Q. And there was back and forth between you and Mr. Dratel about risperidol. The defendant was taking risperidol, correct?

A. Yes.

Q. I'm not going to go through all of the calls but I do want to hit a theme, perhaps. And let me use Government Exhibit 12. Do you have that? It's the February 10 call. It's at 5:47. And Mr. Dratel went over two passages with you.

The first passage is on page two and it starts out, I am really convinced these people, they want to kill me because of things that I know and mathematical algorithm and all that stuff. Then it goes on, the point is the lady when she gets the phone call thinks he can tell her husband she don't understand him any more. The handwriting is very different in that passage?

A. Yes.

Q. And you thought this passage as significant and some of other passages Mr. Dratel read because it showed Mr. Bejaoui was having delusions or articulating delusions, not just with evaluators but also with his wife, right?

A. That's right.

Q. You saw sort of lack of external motivation for him to

articulate those calls with his wife, right?
A. Certainly, this one in particular, yes.
Q. No reason why he would say that?
A. Start being gibberish to her in this call. I don't see any possibility.
Q. This call was before you told Mr. Bejaoui you had listened to his calls, right?
A. That is correct.
Q. And that was significant in, as to whether Mr. Bejaoui would have had a reason to malinger on this call, right?
A. That's true.
Q. Do you know if Mr. Bejaoui had been told previously that his calls were monitored?
A. I assumed that when people go to the prison they must get a sheet of paper they're explains that. I can't imagine the government would keep that a secret to the inmates. So assume in that context probably, yes.
Q. Do you know if signs are posted in the area where calls made indicating that calls are monitored?
A. I've never been in that area but I would not be surprised if that were true.
Q. One feature of this passage that pointed out is significant is that Mr. Bejaoui is making these statements and his wife is indicating that she can't understand them, right?
MR. DRATEL: Objection, your Honor. I am not sure

which passage I'd like just to -- if Ms. Kovner could identified.

THE COURT: We've seen a couple of ones. Go ahead.

BY MS. KOVNER:

Q. That was significant to your interpretation of what's going on here. And talking, specifically, about page two line 19 I guess through the bottom of the page.

A. I am sorry. I got sidetracked. What was the question again?

Q. Sure. Is this is February 10? It's page two. And one of the features you commented on was that Mr. Bejaoui's wife does not understand what he is saying and that that was significant in your interpretation of how he is manifesting, generally, psychotic symptoms?

A. It appears to, yes. I don't understand what you are saying either. Neither does she actually hear the call. It is like what are you talking about is the tone of voice.

Q. That was significant that you couldn't understand and she couldn't understand it?

A. Right. I can't understand why he would say this to her other than because he needed to communicate something that made no sense.

Q. Okay. And let me go to the page five which is the other passage in this call that Mr. Dratel pointed out where he says, I am a stupid man but you know you can't blame me. I was

taking pain medication. I did not tell you bout it. I was taking pain medicine because I've always suffered from it and I don't want people to ask me about my pain because it reminds me of my childhood.

A. I see that.

Q. That passage was significant because Mr. Bejaoui was reporting this pain complaint in a context where you didn't see an incentive for him to make it up, right?

A. Actually, Mr. Dratel -- I am not sure. I wouldn't come that conclusion. I didn't find that that particularly significantly other than the fact that it illustrated the fact that he doesn't -- it's almost like malinger well. He likes not to talk about. I assume the point Mr. Dratel is making that this was an example of how he actually doesn't like to talk about his pain rather than like to go talk about it all the time. I didn't see this as having anything to do with whether that recorded phone call or not. To be honest, I want sure he when he did that, I hadn't highlighted a lot of these things that I felt were evidence of psychosis on the phone call. That wasn't one of the ones I had highlighted. So I wouldn't take that as evidence to fit into that hypothesis that I had been making.

Q. The significance of this passage you see that's been evidence of malingering well, that is pretending to feel --

A. It shows that he doesn't always, his style that sometimes

he would like to not tell people about. That was my understanding.

MS. KOVNER: Nothing further.

THE COURT: All right. Thank you. You may step down.

Next witness for the government.

MS. KOVNER: Your Honor, we discussed briefly with Mr. Dratel at the break because Mr. Cochrane has a plane flight we were hoping that it would be possible, and I think Mr. Dratel has no objection, to put on Dr. Cochrane before the second defense witness or the possible second defense witness.

THE COURT: All right. You want to take him out of order?

MR. DRATEL: Yes. Fine.

MR. WILSON: The government calls Dr. Robert Cochrane.

THE COURT: First witness was the witness for the defense. The second is a witness for the government.

MR. WILSON: Your Honor, at the witness' request we could take a two minute break for the restroom.

THE COURT: Of course. Let's take five minutes.

(Recess)

DR. ROBERT EARL. COCHRANE,

called as a witness by the Government,

having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. WILSON:

Q. Good afternoon, doctor.
A. Good afternoon.
Q. What do you do for a living?
A. I am a forensic psychologist and the director of clinical training at the federal medical center in Butner, North Carolina.
Q. How long have you been a forensic psychologist?
A. 14 years.
Q. Are you license to practice?
A. I am, in the state of North Carolina.
Q. Do you specialize in any particular area?
A. I do. While my degree is in clinical psychology I went on to specialize in forensic psychology.
Q. Are you board certified?
A. Yes, I am, by the American Board of Forensic Psychologists.
Q. What additional training do you need to receive to become a board certified forensic psychologist?
A. You need a certain number of years of experience, training and supervision. It typically a requirement or expectation is you complete a forensic fellowship which I did in a Massachusetts medical school. And you have submitted -- well, it was a lengthy process, takes about a year or more to complete. But you have to have certain credentials, degree and experience as I mentioned. You then need to pass a written examination. After which you need to submit what are called

work samples or basically reports and examination that you actually completed to the board. And the board reviews those work samples to see if they're sufficient quality to continue to the next and final stage. If you do pass at that stage you move on the oral examination where it's a three hour examination where you defend your practice, basically, in front of an examination committee. And then if you succeed you obtain your board certification.

MR. WILSON: May I approach, your Honor?

THE COURT: Yes.

BY MR. WILSON:

Q. Handing you what has been marked as Government Exhibit 1A.

A. Yes. That's my curriculum vitae.

Q. Is that your current CV?

A. It appears to be.

Q. Is that the CV you provided the government as the most current? And you can take a look to make sure it's the same.

A. It looks like the one that I forwarded to your office, that's right.

MR. WILSON: The government offers Government Exhibit 1A.

THE COURT: 1A admitted.

(Government's Exhibit 1A received in evidence)

Q. In an effort to move through this as fast as possible, doctor, I'm not going to have you describe everything that's

part of your credentials and your background. But in terms of your educational background, are there any particular forensic training or experience?

THE WITNESS: Significant amount of forensic training, both with seminars, workshops, continuing education, in addition to formal course work during my graduate school training and then finally practical experience both at the practical, what's called a practical level as well as internship, then, of course, my fellowship that I mentioned.

THE COURT: What does a forensic psychologist do and what is forensic training?

THE WITNESS: Forensic training typically includes having certain experience, practical experiences in clinical and forensic settings. So that you can get exposure and practice to professionals in the assessment diagnosis of individual variety of medical disorders.

THE COURT: How does forensic psychology different from clinical?

THE WITNESS: Typically clinical psychology, there is overlap. Clinical psychology involves assessment and diagnosis of medical disorders and typically also the treatment of various disorders through different types of individual and group psychotherapy for example.

Forensic psychology is primarily focused on the evaluation component and the evaluation and diagnostic and not

so much on treatment, per se. And it's the application of scientific principles of psychology and the mental health arena to answer certain legal questions posed to you.

Q. Are there any --

THE COURT: I am sorry. I need to understand. Clinical psychologist diagnosis disorder.

THE WITNESS: Correct.

THE COURT: Like psychiatric disorder, psychological disorders?

THE WITNESS: Yes, your Honor.

THE COURT: What does a forensic psychologist do?

THE WITNESS: They also do what a clinical psychologist would do with the additional training and expertise in assessing criminal defendants, civil plaintiffs to determine if the mental disorder has some relationship to the legal question that's posed or entered in the matter such as competent to stand trial. If the individual suffered in a civil case some kind of a personal injury that resulted in a mental or emotional damages. So that's the application of that clinical knowledge to the legal setting.

THE COURT: Thank you.

BY MR. WILSON:

Q. As long as we're discussing the subject, doctor, are there any significant differences in how you approach the evaluation of a subject in a forensic setting versus the evaluation of a

patient in a clinical setting?

A. Yes, there are.

Q. What would some of those differences be?

A. Well, in a forensic setting you are going to bring a unique set of skills and procedures to play. In a clinical setting, for example, you oftentimes will have the patient come into your office and you make assumptions about the voracity of what they're telling you because they're coming for help. There is not the external pressure, so to speak, of a legal matter as present.

You also would utilize -- well, let me back up. The goals of assessing and treating someone in a clinical setting versus a forensic setting are also different, such as in this matter. I am not hired by this defense or the prosecution but as a forensic psychologist you train to be as object and neutral as possible anyway, to understand the patient but not to help them per se, nor to help them but to answer questions for the judge or whoever it is that's making the referral. So the approach is different. The goals are different. And the procedures as I mentioned are also different.

Q. What are some of the differences in the procedures?

A. Procedures, generally, in forensic settings or forensic matters will be more exhaustive and comprehensive given the importance of truth finding. So for example, utilizing multiple sources of information, not just what a patient tells

is critical. And that is a source of the information we've already I think brought those up today, clinical review of documents, talking to collateral informants, interviews over multiple periods of time, sometimes psychological testing and so on. So it's basically more comprehensive.

Q. And, doctor, you obviously have testified that you work at MC Butner, correct?

A. Yes.

Q. And just because some issues has been raised about what type of facility that is, can you describe for us the facility that you have at Butner?

A. Sure. First of all, Butner is a complex that has five institutions, one of which is a federal medical center where I work. It is a 900 bed hospital for psychiatric and medical patients. We serve federal courts from throughout the country and the territories of the United States by evaluating and treating defendants pretrial nature. As well as treating sentenced inmates in our system who is sent for in maybe care. Approximately 300 beds ever hospital are devoted to the psychiatric or mental health mission, the majority of those again are pretrial defendants. So at our hospital which is a Jayco credit as the Joint Commission or credited, a hospital for this country. We're Jayco credited from facility that had a number of different specialties beyond psychology and psychiatry but we have oncology, dialysis. We have a surgery

unit, an emergency urgent care units. We have physical therapists, our pharmacy. So, we're basically a medium sized hospital that also serves as a prison with a variety of specialists like I mentioned.

Q. Is it fair to say that you are a full treating hospital?

A. Yes. And we're also a teaching hospital as well. There are a number of professions including psychology at which I head where we're training students, training people who are going to be professionals in that those areas outside psychology that would include social work, psychiatry of fellowship, physical therapy. Nursing students come all the time. There's a variety of others I know I am forgetting but we do a lot of teaching.

Q. And what you just testified that you are in charge of the training program for forensic psychology at Butner?

A. For the doctoral psychology students.

Q. What does that job entail?

A. It encompasses about 50 percent of my activities now and it entails the supervision of the internals and the responsibility of coordinating their training while they're with us for a year long full-time internship. So I do a number of things. I teach seminars, supervise them, individual group settings. I coordinate the supervision with other professionals on staff and a number of other administrative things.

Q. Now, do you have any other teaching experience or teaching

role?
A. Teaching role currently?
Q. Yes.
A. I am also an adjunct faculty at the University North Carolina at Chapel Hill. I have taught select courses at Duke University.
Q. Are you a member of any forensic professional organizations?
A. Yes, I am.
Q. What would be the most notable so as not to drag it out?
A. I am in, I guess, the most notably and I'll try to be brief, is the American Academy of Forensic Psychology and American Board of Professional Psychology. I'm a member of both of those. In addition, I am now on the examination faculty of the American Board of Forensic Psychology. So I, basically, help and select and determine those who are applying to become board certified whether they meet the requirements.
Q. And have you published any articles in the area of competency and malingering?
A. A couple. I'm primarily a clinician, so I don't have much time for research given my administrative duties and clinical duties but I have published a handful of articles.
Q. Now, you testified that about 50 percent of your time now involves the training mission at Butner. What's the rest of your time spent doing?

A. Doing pretrial court ordered evaluations.
Q. What type of evaluations do you do?
A. Primarily competency to stand trial. But I also answer other questions at the Court's behest such as mental state at the time of the offense and whether the individual meets criteria for civil commitments or dangers due to mental disease or defect and then a handful of other things.
Q. As part of those responsibilities what types of patients do you personally deal with?
A. Given we're an inpatient facility we have a wide variety of patients. And, in fact, I'd be willing to guess every diagnoses listed in the DSM I've seen at our facility. We have very impaired individuals. I have several on my caseload now with brain injuries due to gunshot wound. Many individuals with psychotic disorders such as schizophrenia schizo effective disorder, mood disorders like bipolar disorder, major depression, substance abuse problems and personality disorder and the goes on and on. But we see quite a variety and, again, because we're inpatient we see some of the worst of the worst.
Q. And do you treat significant numbers of people who have been found incompetent to stand trial?
A. A large percentage of our time is treating individuals with serious mental illness to restore them to competency.
Q. Approximately, how much competency to stand trial evaluations have you personally performed?

A. Just competency, about eight or nine hundred, that ballpark.

Q. Have you previously testified in court as an expert in forensic psychology?

A. Yes, I have.

Q. About how many times?

A. I can tell you precisely this would be the 98th time I've testified.

THE COURT: As all or essentially all on the issue of competency.

THE WITNESS: Your Honor, I'd say about 80 percent are competency.

MR. WILSON: Your Honor, to the extent necessary I'd offer Dr. Cochrane as an expert in forensics psychology.

THE COURT: I'll allow him to answer opinion questions in regard to the defendant's competence.

BY MR. WILSON:

Q. Now, when you conduct these competency evaluation at Butner can you tell what the standard evaluative tools you use are?

A. Well, as I mentioned, it's important to use a variety of tools or information in doing these kinds of evaluations. So it is typical that in addition to interviews and ongoing observations, not just by myself or but other staffer members at our facility are very important, as well as reviewing collateral documents such as medical records, criminal records,

school records, whatever is pertinent. If it's appropriate and indicated we often administer psychological tests to assist in answering questions and talking to collateral source information. Sometimes the attorneys, sometimes it's important to talk to family members, perhaps, witnesses and things like that. And then after gathering all that information and analyzing all that information, of course, generating a report about our findings.

THE COURT: Dr. Cochrane, you said you testified my extension of here remarks that you testified about 80 times in court in regard to the question of whether or not a defendant was competent to stand trial, is that correct?

THE WITNESS: I would say that's, yeah, roughly. Don't hold me to the exact number but that's a rough estimate, yes.

THE COURT: Do you have an estimate as to what your conclusions were as to how many patients? In other words, do you know if in all of those 80 patients, give or take a few, you reached the conclusion that a patient was competent or is it 50/50? Do you have a sense?

THE WITNESS: Of the 80 patients I testified on or the 800?

THE COURT: 80 you've testified on.

THE WITNESS: Well --

THE COURT: I'll take it both ways, actually. Let's

start with the 80 you've testified about.

THE WITNESS: On the 80 I've testified it's hard to answer, your Honor, but I'll see if I can figure it out.

THE COURT: I don't want to guess but if you have the basis --

THE WITNESS: I might be able to give you a decent estimate. The majority of the patients that come to us have already been found incompetent. Eight or nine times out of ten I agree with that finding, so I initially concur or believe they're incompetent to stand trial. Following treatment, however, we have found and it's consistent with the broader literature that, approximately, 80 to 85 percent of those individuals, their competency is restored. So at the end of the evaluation period quite often probably 80 to 85 percent of time I am then declaring them competent.

THE COURT: After restoration?

THE WITNESS: Yes.

THE COURT: Mr. Bejaoui came to you from FMC Devens, correct?

THE WITNESS: Correct.

THE COURT: Was it for the purposes of determining whether or not he could be restored to competence?

THE WITNESS: It was to restore him to competency and then determine whether or not those efforts were successful. But in many cases, as I am sure you can understand, we have

individuals come to us and when we perform our own independent assessment we sometimes disagree with the prior assessment. So we have to reach our own determination. For example, I have had patients where a prior examiner may have concluded that he suffer from schizophrenia. I may have concluded, you know what, he was malingering symptomatologies of schizophrenia, therefore, we can't treat him for schizophrenia. That wouldn't he be appropriate to do. So we offer our opinion to the court.

THE COURT: So this case restore them to competency, correct?

THE WITNESS: Yes, that is my understanding under Section 42D he was sent by that court, so I was under the assumption that we would --

THE COURT: So, no, he first went to Devens. What was your --

THE WITNESS: He was found incompetent to stand trial.

THE COURT: And sent to you to restore competency.

THE WITNESS: Correct.

THE COURT: Your conclusion was that --

THE WITNESS: My conclusion was that he did not suffer from the problems that were described at Devens and I believed he was competent to stand trial.

THE COURT: In fact, your primary diagnosis is of malingering.

THE WITNESS: Correct.

THE COURT: You've heard Dr. First's testimony that the primary diagnosis, essentially, was major depressive disorder with psychotic aspects, correct?

THE WITNESS: Correct.

THE COURT: Okay. Why do you disagree with Dr. First?

THE WITNESS: I disagree for a few reasons. One, I don't believe he suffers from major depression and to have major depression with psychotic features you first have to have a very serious major depression because there's gradation as you can imagine. There's mild, moderate, severe. As the DSM indicates it's only with the most severe depressed individuals, even among those not many have psychotic symptoms but some in fact do, it's only that category that suffers from psychosis. I simply disagree with the fact that I don't believe Mr. Bejaoui has five of the requisite nine symptoms to qualify for a major depressed disorder.

People who are suffering from major depression they have recurrent thoughts of death wanting to die. They won't don't want to get out of bed quite often. They, certainly, aren't interested in what happens to them. They don't talk to family members. They sort of shut people out. They don't sleep well. They don't eat well. They lose a lot of weight or they gain a lot of weigh. They can't concentrate. Their mood and affect is consistently depressed. They've lost all interest in activities that they've previously enjoyed and a

few other symptoms.

Now, I did believe that Mr. Bejaoui had some dysphoria and depressed and anxious mood and he may have had some trouble concentrating. But for the two months he was with us I did not identify sleep disturbance, daytime fatigue. He only very intermittently and I think it was -- perhaps, it was on a phone call he mentioned suicidal ideation but he made no suicidal gestures, no notes, no behaviors, whatsoever, that were consistent with that and he ate and he slept. Like I said, I think I mentioned he slept well.

So, I wasn't seeing again the requisite symptoms to even diagnose a major depression but be that as it may, let's assume he did suffer from a major depression. These psychotic symptoms he reported I believe were very consistent and very, very atypical. For example, he wasn't just reporting hallucinations or delusions of a depressive type or persecutory affect. In fact, if you look at the DSM typically people have transient auditory hallucinations, he was reporting not only ongoing auditory hallucinations but visual hallucinations and tactile hallucinations, the latter an example of which is the fact that he believed terrorists were coming through his walls he reported and were hitting him on the back, head and back and physically hurting him causing him pain which against suggest a tactile hallucination which is extremely rare even among others with more primary psychotic disorders. And it's certainly not

even mentioned in the major depressive disorder of psychosis section of the DSM. Furthermore, he not only again was reporting persecutory delusions, he reported grandiose delusions, again, inconsistent with that diagnosis. So those are a couple or a few of the reasons why I respectfully disagreed with Dr. First's opinion.

MR. WILSON: Your Honor, if I could ask a quick clarification question?

BY THE COURT: Sure.

BY MR. WILSON:

Q. You mentioned grandiose delusions. Can you explain what those are?

THE COURT: He thought he would have an impact in the peace process in the Middle East.

THE WITNESS: Yes. That he alone had had mathematical formulas that people were trying to obtain and he had answers that is no one else had.

BY MR. WILSON:

Q. Why is that inconsistent with --

A. You don't see it with mayor depression. Is it theoretically possible? Sure. But we're talking about probably. Then it would be -- I've never seen it in my career and nor is it even mentioned in the DSM.

Q. What disorders would you have to have in order to present the symptoms that the defendant presents here?

A. Well, he presented a lot of symptoms but both physical and psychiatric. Are you assuming that if you were to accept everything he's reported on face value?

Q. Assuming that his presentations and his reports entirely accurate and there is no malingering or any form of feigning or what have you, what would he have to have to show these types of impairments?

A. He would have to have or he could have the following: A somatoform disorder, a major depression, probably a separate psychotic disorder, a schizophrenia and, certainly, have to have dementia and a perhaps an anxiety disorder. Since he is reporting symptoms across those various categories, most notably, the cognitive problem that he reported were -- I was going to say consistent but they're really inconsistent even with individuals who have Alzheimers dementia, and they are not perfectly fine one day, then no intervening event unless they're shot in the head, that would explain them being amnestic and not knowing their name, not knowing how many fingers someone is holding up, not knowing their date of birth. I have patients with those legitimate problems, dementia and TDA all the time. And I'm sure other doctors could attest to those individuals, in fact, can clearly recall that basic overlearn, what we call overlearned information. But sorry I may have got a little are afield. The bottom line is you'd have to have dementia, psychosis, a mood disorder and perhaps

some type of somatoform.

Q. Doctor, in your experience with the almost one thousand comp evaluations you done have you ever seen anyone presenting that variety of severe disorders occurring within one year or one and a half years without prior history?

THE COURT: What variety of severe disorder?

MR. WILSON: I'll withdraw.

Q. You describe the types of disorders that the defendant would have to have in conjunction with each other to explain all his symptom, correct? And that would be -- maybe we should clarify even further. How many of the disorders you just described would the defendant have to be simultaneously suffering from to explain all the symptoms he's reporting?

A. Well, again, the four that I mentioned, assuming it wasn't malingering, if you are assuming it's all true and it's not a malingered presentation what did I say? Somatoform disorder, a mood disorder, psychotic disorder and dementia, one could argue, well, the mood and the psychotic disorder could be one in the same. Sometimes people with bipolar may -- we clearly have to have at least three or four major mental illness.

Q. Have you ever seen someone present with all those illnesses at once to this degree?

A. Maybe not to this degree but I have seen patients who have reported these symptoms. I've never seen a patient who actually suffered from all three or four of those

simultaneously.

Q. Going back to a point that you were making a moment ago about the degree of dementia the defendant would have to be suffering from. You mentioned some particular example that you found to require that degree of dementia. Just want to go through a few to make sure we are on the same page that's been discussed a bit before. And in your report which is in front of you, for the record it's Defendant's Exhibit D, page 11 to talk about the initial admission.

A. Yes.

Q. One of the statements he made at that time was he didn't know his date of birth?

A. Yes.

Q. And that he said that he was age 50?

A. Correct.

Q. How old is he in fact?

A. 38, at least the time of that report I believe he still is.

Q. What type of cognitive disorder could explain that if it was actually an accurate presentation?

A. Couple different things, actually, could explain it. Dementia as I mentioned, severe dementia could explain it, a delirium could explain it which could be due to a medical illness or a substance that the person was taking could cause them to be very confused and report an grossly inaccurate information. Those are the two that come to mind delirium or

dementia or traumatic brain injury, sorry, but again it's of the cognitive.

Q. Let me ask you one by one, does the defendant have a traumatic brain injury?

A. No. He reported that he suffered from one. I was not able to obtain any records of such and in talking with his wife who has known him for 14 or 15 years, she has not aware of any such accident, that coupled with the fact he was functioning relatively well, running his own business and working. So even if he were to have suffered some kind of accident that we don't have the records for, it, obviously, wasn't debilitating enough to interfere with his financials. He had some problems before incarceration but nothing like this until he was arrested.

Q. Well, to be clear, could you suffer a traumatic brain injury and 15 years later have an onset of this type of -- withdrawn.

Could a traumatic injury 15 years ago explain these types of symptomatology occurring all at once now?

A. No, it could not.

Q. And speaking of dementia now, does the defendant have the requisite symptoms to be diagnosed with dementia?

A. No, none of the doctors have suggested that.

Q. Would that also be true of the third possibility that you mentioned which is now escaping me?

A. Delirium?

Q. Yes.
A. He doesn't have any kind of infection, nor was any substance detected in his system at the time of this interview would suggest delirium was the cause.
Q. Now, your ultimate diagnosis in this case, the primary one was lingering, correct?
A. That's the primary, yes.
Q. That's malingering as to both his physical symptoms, physical reported symptoms and his mental symptoms, correct?
A. Yes. There was inconsistencies on both grounds. That doesn't mean however every piece of inaccurate information he provided I attributed to malingering. Some of it is part of his histrionic dramatic way of presenting information. So taken in whole I think there were medical and psychiatric symptoms, certainly, that led to the conclusion of malingering. But each and every incident isn't necessarily indicative of malingering. Could be to some degree anxiety and histrionic personality and features.
THE COURT: To change the subject slightly, got to let the lawyer come back is the defendant's affect today is part and parcel of the malingering?
THE WITNESS: Do you mean his -- the way he is right now?
THE COURT: Yes.
THE WITNESS: As part of malingering? I don't know

how to answer that. He looks to be unattentive to the proceedings.

THE COURT: Yes.

THE WITNESS: I couldn't explain why that would be other than that's an intentional behavior.

THE COURT: It could be part of depression?

THE WITNESS: Part of depression? It could be if he is so sleep deprived recently. Let me add, I don't know if there's been medical changes, problems since he left our facility. That could possibly be an explanation for his behavior today. I am not aware of that.

THE COURT: Is this how he presented at Butner?

THE WITNESS: No, not at all.

BY MR. WILSON:

Q. Could you just explain that as long as we're talking about it. What is different about his presentation now versus at Butner?

A. At Butner he was very animated most of the time. He was, as Dr. First had testified and others have reported, very difficult to interview. Asking him questions and getting a direct answer was not easy. He often focused on certain complaints or issues he wanted to talk about and it was difficult to address other matters. He was very dramatic and panting and like I said very animated in his behavior and energetic on most occasions when I met with him and not at all

like with sedate position he is in now.

Q. You mentioned just a moment ago histrionic personality features.

THE COURT: I am sorry. In the course of the past few years that he's been a defendant here his affect has changed dramatically. He started off, to my observation, being very involved with the first of his several lawyers, the first two of his several lawyers, actually, having heated disagreements with them in court. I don't know what they were about but it was clear there were disagreements very animated and even loud and agitated. In general then his affect, I described it as going downhill. I don't know how that translated in medical terms but he became less involved and then not involved at all. And at one point he was then in a wheelchair and this is all in the records. In fact, at one conference was he not only in a wheelchair but was slumped over with his head down for the entire thing almost lining like a rag doll. His affect now is substantially better than that but you can see how it's gone through a whole series of changes.

THE WITNESS: True.

THE COURT: Is that something that you only saw a section of that because it was after?

THE WITNESS: That's all I am reporting to is that two month section. I would agree with you in looking at the bigger picture as I reviewed records, he has fluctuated, absolutely.

And some of those inconsistencies are actually in the presentation are noteworthy. But, no, I would agree that he is a sensitive sort of labile, moody guy who one minute will be angry and demanding, next minute -- not minute, but shortly after that he'll be crying and wanting people to help him and soliciting assistance but it's very dramatic in that sense but it does change over time, absolutely.

THE COURT: What does that tell you about malingering versus any of the diagnoses made by Dr. First.

THE WITNESS: Well, I am not sure other than we both agree he's got histrionic features of a personality disorder and that his --

THE COURT: That's your access two.

THE WITNESS: That's his personality. That is his character. That's just how he carries himself. He might be happy with his lawyer one minute, then cursing him out the next. It wouldn't shock me. So I am not sure if I answered your question, your Honor.

THE COURT: Well, what I've described suggests is that one part of malingering or is that one part of massive depression or is that not telling us anything?

THE WITNESS: It could be. I don't think it says very much. It could be depression. People who are chronically depressed anyway as he's reported, you wouldn't expect that fluctuation. But then again he's got histrionic personality,

so it's difficult to answer that. I didn't put to much stock in that in my analysis or my determination of malingering, that is his mood fluctuations. I didn't use that to say, oh, look he's malingering, his mood and affect changed. There was plenty of other information that led to my conclusion and that wasn't significant.

THE COURT: Thank you.

BY MR. WILSON:

Q. Just to be clear, could the type of histrionic personality features you've diagnosed the defendant with cause him to be incompetent to stand trial?

A. No, I haven't come across anyone whose personality has gotten in the way or even been considered mental illness or mental disease that would get in the way of his behavior. It could make interactions difficult with counsel but it's sought to be to a large extent volitional and within one's control. It's like someone who's got a bad temper, that bad temper gets in the way of relationships at times but you wouldn't say that the person was incompetent to understand the charges or to work with someone if they were motivated to do so.

Q. Then to turn back to malingering, starting at 22 in your report, can you briefly summarize what, obviously, is in the report the factors that led you to conclude that the defendant was faking his symptoms or at least the majority?

A. Sorry. There's something on page 22.

Q. That's where the report starts.
A. You want me to discuss the reasons I felt he was malingering?
Q. Yes.
A. Well, see if I could summarize this. There were inconsistencies in his report to different people at different times. There was also inconsistencies in his symptoms with known psychiatric problems. And there was inconsistencies within his own account to the same individual. So there were different categories of inconsistencies. We've mentioned some of those in court. I don't know if you want me to, obviously, inaccurate information he's given about having cancer in his chest or having traumatic brain injury and being unconscious for several weeks.
Q. Let's stop there. You mentioned that the inaccurate or inconsistent reporting is one of the issues, correct?
A. True.
Q. I won't go through the examples since they're in the report but what is the relevance of that to your determination that he is malingering?
A. It shows that you have to be cautious. And if you don't have a credible historian in front of you not to take what he says at first value and be cautious about attempts to deceive. So I would try to be cautious of that. I am not sure if this is also what you are asking but you also need to determine the

motivation, as Dr. First said, because it's not always malingering. As I mentioned in the report I believe, I tried to rule out other explanations such as somatoform disorder or factitious disorder. I can't remember if I mentioned factitious specifically but you have to determine what the motivation is. That is often a very difficult thing to do. I can explain why I ruled those out but I don't believe that those our other conditions.

Q. Since you raised it let's be clear, those go to his physical conditions, correct?

A. Somatization can include psychiatric and neuropsychiatric symptoms but in case largely physical symptoms.

Q. Okay. And the physical symptoms that the defendant's described here are not the basis for anyone's conclusion that he is not competent to stand trial?

A. No. Well, whether he has legitimate physical symptoms, some degree of pain, again that's subjective, it's hard to say or whether he has somatoform disorder, I can't imagine that having any impact on his competence to stand trial.

Q. So the relevance of your determining he was malingering rather than having somatoform would be what as to competence?

A. Can you repeat that?

Q. You determined that the physical complaints that defendant suffered were a result of malingering rather than somatoform, is that right?

A. Correct.
Q. That does not go directly to the question of whether he's competent, right?
A. Not directly, no.
Q. Did you find it relevant indirectly?
A. Did I find it relevant indirectly?
Q. Yeah.
A. It's relevant in the sense that if someone is malingering and also doesn't have a legitimate problem then that's pertinent because that's the first problem with the test.
Q. Which test?
A. I'm sorry. The standard under 4241D you have to have a mental disease or defect. If determined the person doesn't have a mental disease or defect then it's a moot point as to other issues.
Q. Would it be fair to say that one who reports physical and mental symptoms and is feigning the physical symptoms, would that person be more or less likely to be feigning the mental symptoms as well?
A. Well, again it's a credibility issue. If someone you know is being deceitful on certain issues it doesn't mean they're being deceitful in this other category, but concerning what you are going to believe or not believe can be difficult. If someone you know is deceitful in some area then, yes, you have to have serious concerns about being deceitful in their

presentation as a whole. But, again, it doesn't necessarily mean someone couldn't be feigning one disorder but legitimately have another.

Q. Let me just ask a couple of specific questions about some of the history that you got from the defendant and from his wife. Do you ever ask the defendant about mental health problems in his family?

A. Attempted to, yes. I don't believe he gave me a direct answer.

Q. He didn't tell you or -- withdrawn. Did he tell you whether he had a brother with schizophrenia?

A. He never mentioned that to me or other staff, no.

Q. He ever mentioned he had a brother who was in a mental hospital in Tunizia?

A. No, he did not.

Q. Is there anything in the record that indicates that he had a brother with schizophrenia?

A. Anything in the record I reviewed? Not -- the time of this report or after?

Q. With the ex --

A. With the exception of Dr. First's report, no.

Q. Anything that indicated he had a brother in a mental hospital?

A. Again, no.

Q. Now, did you interview Mr. Bejaoui?

A. Yes.
Q. You, personally?
A. Yes.
THE COURT: You were his main or treating psychologist, correct?
THE WITNESS: I was the main or primary evaluator. Dr. Herbel was the treating. We work as a team.
BY MR. WILSON:
Q. Did you interview the defendant's wife, Marie Bejaoui?
A. No. Dr. Herbel did that.
Q. Do you know what the content of their conversation was?
A. Yes. Dr. Herbel shared that with me.
Q. Did defendant's wife tell Dr. Herbel that he had had frequent bouts of paranoia?
MR. DRATEL: Objection. It should be stated --
MR. WILSON: Withdrawn.
Q. Did Dr. Herbel tell you that, whether Ms. Bejaoui had stated that her husband had had frequent bouts of paranoia?
A. He indicated the only problem she reported were of an anxiety and depressive nature.
Q. And you reviewed the report of Dr. Channel from Devens, correct?
A. Yes.
Q. Do you remember whether he interviewed Ms. Bejaoui?
A. In the record it indicates he did.

Q. And did he report that Ms. Bejaoui had told him that the defendant had bouts of paranoia?

A. No, that is not mentioned in the record.

Q. Now, what is the relevance of the absence of a credible family history of these types of ailments to your diagnosis?

A. Well, it carries some but not much weight. It is important to ask about family history because some disorders do have a high genetic load. That is, if their immediate family members who have that condition that increases the chance that the individual might develop that disorder. However, even among the most genetically tied psychiatric condition it's not even over 50 percent. I mean and with schizophrenia the number's significant below that. There is, it's certainly a genetic link for biological immediate relatives with schizophrenia, for example, but more times than not, if the sibling has schizophrenia the other sibling or other siblings will not. So, again, it carries some weight in the overall analysis but not a great deal.

THE COURT: That's an artifact, as it were, of your below 50 percent number, right? In other words, if it's less than 50 percent likely that immediate family member will have this, that means that it's more likely than not that they won't?

THE WITNESS: Correct. But, again, if someone had five family members with schizophrenia --

THE COURT: It's still going to be the same analysis for each and every one?

THE WITNESS: Correct.

THE COURT: All right.

BY MR. WILSON:

Q. What about the defendant's personal medical history? What did you find relevant about that in terms of your diagnosis?

A. His personal medical history.

Q. His mental health history?

A. Mental health history, okay. What did you learn about that?

Q. What about it did you find relevant in reaching your diagnosis?

A. That he had been treated for -- supposedly, been treated for problems related to anxiety and depression, never been treated for any psychotic symptoms or problems and never psychiatrically hospitalized which suggested to me he was never -- or diagnosed with a psychotic disorder before entering the prison system recently. I don't know if that answers your question.

Q. What, if anything, any conclusions did you draw from that?

A. That it would be unlikely at the age of 38 that he would develop severe debilitating psychiatric conditions as such dementia, schizophrenia or psychosis related to a major depression. The likelihood of that would be way, way down.

THE COURT: What's the likelihood that living with his wife it would go undetected as a debilitating psychiatric condition? Or put another way, assume there are lots of people out there on the streets of New York with a severe debilitating psychiatric condition.

THE WITNESS: Correct, your Honor. They're homeless and I'm sure you've seen several of them. He had a loving wife. It appears he was able to function and work adequately to help support his family and I would suspect that if he were suffering from psychosis that she would have helped do something about that.

THE COURT: Is it possible that as a layperson she would be characterizing what you characterize as psychosis instead using whatever the words she did were -- I don't know what it was "difficult", "paranoid", I don't know the words she used.

THE WITNESS: She didn't use those words with me but later I understand she did.

THE COURT: Isn't that entirely possible? In other words, you would say he was exhibiting psychosis. A layperson, loving wife would describe it in the terms she described it in.

THE WITNESS: Certainly, in fact, that's what's more important. I am not concerned what label a family member gives it. I want them to describe the behavior they see in their loved one. So if they're describing what I would consider more

of the psychotic behavior, that is oh, my God, he thought people were going to kill him. He got a firearm, was carrying it around to defend himself, I've got patients where they've painted their windows all black or put shades up and will stay in their house for weeks and weeks at a time because they're extremely fearful they're going to be killed by a mafia or some other groups, it's those kinds of behavior that I want to hear from a family member that would help me determine the proper label.

THE COURT: And the record does not reflect those as coming from Ms. Bejaoui, is that correct?

THE WITNESS: Correct. It was only until I read Dr. First's report where she had indicated some level of either claustrophobia or fear which, again, I don't know if it was legitimate fear because he didn't make or made enemies or it was a paranoid fears, there's not enough detail to make that determination. But it was only at that last evaluation that I read anything about that.

BY MR. WILSON:

Q. Just to clarify one thing, doctor, if you look at page four of your report in the first full paragraph probably about ten lines down there's a list of prescriptions that Ms. Bejaoui reported to -- withdrawn. There's a list of prescriptions that Mr. Bejaoui reported to Dr. Herbel that the defendant had been on?

A. That's right.
Q. Prozac, Lexapro and Clonipin?
A. Yes.
Q. Are you any of those antipsychotic medications?
A. No.
Q. Would any of them be appropriate for someone suffering from severe hallucinations or persecutory delusions?
A. No. I would presume that the person who prescribed those if they thought he was delusional or suffering from psychosis, it is would be practically malpractice not to prescribe the appropriate treatment.
Q. One of the things you mentioned earlier that was a factor in the malingering diagnosis was defendant's inconsistent behavior with people. There's some examples of that from Butner that are in the report and his interactions with the staff. Can you explain any of those that are particularly notable?
A. Well, for the majority of the time he presented again, he is very impaired, unable to follow and answer questions and what not, histrionics as I mentioned and very confused. Like he didn't know his name and how old he was and all of that. However, there were a few incidents where he was very lucid and organized. One in particular has to do with his wanting to and eventually obtaining a notarization by one of our notaries for a power of attorney form so his wife could be power of attorney

over his affairs. I could explain that interaction or move on.
Q. What did you find -- withdrawn. Did you find anything significant about that?
A. Yes. That was one example of, again, him seemingly being able to when he had a goal in mind, something he wanted to accomplish he was able to organize his thoughts and behavior such as he could accomplish that quasi legal that --
Q. What interactions did he have with your staff in order to obtain the documents that he wanted?
A. He first contacted staff on his unit to find out if there was a notary. Then that staff member contacted a notary who was located in a different location and so he had to make the request. She then went to his unit and spoke with him about the document and getting it notarized and, ultimately, notarized that document for him.
Q. And look at page thirteen of your report, the bottom, the first full paragraph indicates that Mr. Bejaoui actually directed the staff member where to sign the document and pointed out the power of attorney only pertained to his financial affairs?
A. Yes.
Q. Is that consistent with his presentation with you when he was being evaluated?
A. This was striking to me when I heard about this and I poke to Ms. Kelly Forbes who was the notary who worked closely with

him because given how impaired he was presenting, it wouldn't be at all consistent with someone who sort of was, again, organized and able to speak to someone in a very coherent and clear fashion. And she is not a psychology or psychiatrist but is around at lot of severe mentally ill people but when she -- when I talked to her about the interactions she said, I didn't think anything was wrong with him. He spoke normal. He even corrected me or pointed out where to sign. So she saw nothing unusual. So, again, completing that exchange and appearing to be as it was described to me fairly organized.

THE COURT: But isn't that consistent with -- rephrasing. Is that consistent with Dr. First's view that when he is dealing with his wife or good friends or people he trusts he is not impaired by this psychoses, that is the fear, paranoia? And when he is talking to his wife he seems to agree with you as to how different phone calls are but he has an answer for that. That is, it's his wife, the defendant's defenses as it were down. No. More than his defenses, his paranoia and fear isn't present. So he is ordinary and can deal with them. And then he goes the next step and says, ah-hah, even when he is talking with his wife you see this craziness for want of a better word, he's talking about ECT as talking about people poisoning him. So he uses that in support of his position. What do you do with that? And I am suggesting that the power of attorney and search for one is an

extension for his feelings with a loved one who he trusts.

THE WITNESS: I don't know if he would trust the notary or staff member, however, I hear you. My reaction to the first part of your question is that his psychiatric disorder would not explain that kind of inability to organize and remember how old you are, remember how to count, remember to how to spell your first name. If you look under the DSM definition explanation of major depressions, anxiety disorders, even schizophrenia you will not find anything about amnesia or severe cognitive -- So the fact that, I don't find that a credible explanation to say, well, he's comfortable with family so he is not demented but when he is with people who he is afraid of he is.

THE COURT: I think that Dr. First's response to that line of inquiry by Ms. Kovner was, you are right, I can't account for that. I mean I think he was saying, yes, I don't understand how he could not know his name or his first name or the year. So I think Mr. Dratel would tell me if I'm wrong so I think he concedes that anomaly something would be anomalous but still be a valid hypothesis.

THE WITNESS: Well, I don't find that to be a valid hypothesis that you could be so incredibly impaired you don't have dementia, so incredibly fearful, cause you work with a lot of very fearful people. First of all, they don't answer your questions. They don't talk to you. He was engaged with us.

He ate our food. He took our medicine. He saw other physical therapists. Yes, he was anxious.

THE COURT: But I read all of these reports. And your people were -- maybe it was Devens. I am not sure -- actually, having a greet deal of trouble getting him to engage and he was, he only trusted somebody who, I think the Asian woman, he was trusting, I think that was his phrase and he wasn't cooperating with a lot of the professionals.

THE WITNESS: I agree. But I don't think that's paranoia. Because he was wanting help, wanting help and then rejecting that help and being demanding, I don't think that is paranoia at all. Yes, he might have been afraid of people, maybe anxious but, again, anxiety and fear and even -- paranoia and schizophrenia could not explain how he doesn't understand the charge, how he lost that memory. He had that ability, as you had mentioned in court, what has happened in the interim that would explain that. Major depression could not explain that, nor could a somatoform disorder or histrionic personality. So I don't think that is a credible explanation for why it turns on and off that he is somehow afraid. If he was so afraid he would not be engaging at all. And he did sit down with us. Like I said, he did take medicine, although, he claimed to being poison. He did eat the food. So I don't see his behavior at all as being severely paranoid. And even if it was, it would not explain that kind of memory impairment or

loss.

THE COURT: All right. Obviously, if the determination of the Court is that the diagnosis is malingering then this case proceeds and he goes to trial. What happens if the conclusion of the Court is that he does have a mental disease or defect that cannot -- where he can't assist in his defense, what happens then, as you understand it?

THE WITNESS: As I understand it a couple thing could happen. If the Court believes he is not restored to competence no treatment would be effective, then he would proceed to 4246 of the Title 18. If however the Court believes that he might still be able to be restored he would either get sent back to our facility or another federal prison hospital such as Devens or Springfield, Massachusetts.

It probably wouldn't be in the best interest in my opinion to send him back to Butner where we've concluded he doesn't have that problem because it wouldn't be appropriate for us to be treating him for something we don't believe he doesn't have. But another facility would re-exam the issue and determine whether he does, in fact, need some kind of treatment to restore.

So I guess it depends on what the Court concludes that he is still not competent but is potentially restorable, he would be return to a federal medical center if they determined that he, it's not possible to restore him but he is incompetent

then he would be, again, as I understand the statutes, he would be referred back to what's called a dangerous assessment and 4246.

THE COURT: You did hear Dr. First's testimony in regard to the clinical setting in which he found himself which is that view that Butner, he was never there would be prison facility and that's different than a state psychiatric hospital. As you understand the statutes under provisions if he is restorable to undergo that process in the state rather than the federal facility?

THE WITNESS: My understanding, there is no such mechanism and the state would not be obligated to accept him as a patient. So, again, anything is I suppose possible. I've never seen that happen.

THE COURT: I think the statute, specifically, talks about under the control of the attorney general.

THE WITNESS: Yeah. So that's where I think the dilemma is in sending him to a state psychiatric facility. I would dispute that's a better more conducive environment. I guess we could debate that depending on the state facility. I've seen lot of state facilities that I am proud to say we serve our patients much better in my humble opinion. It depends where the place is whether they would accept him.

THE COURT: What federal facilities have the ability to restore somebody to competence, certainly, Butner, is Devens

one?

THE WITNESS: I understand now they have not been involved in that process until recently. I understand now they finally have the resources and staff to do that.

THE COURT: Does that differ from when he was there?

THE WITNESS: Correct, it is different. In fact, he would have been returned to Devens it is my understanding, had they had the resources to undergo or have him undergo the restorative process.

THE COURT: Well, they said they didn't.

THE WITNESS: Yes, that my understanding.

THE COURT: Is there a third facility?

THE WITNESS: There is at the United States Medical Center for federal prisoners in Springfield, Missouri.

THE COURT: Thank you.

THE WITNESS: There is one more in Rochester Minnesota. However, they not taking those kinds of patients but they are a prison hospital as well.

BY MR. WILSON:

Q. We talked about one instance the power of attorney where the defendant's behavior was consistent when he is dealing with your staff. Is there any other notable incidents with your staff where the defendant behaved in an inconsistent way?

A. There were two other incidents where he presented as very lucid and organized and they were both where he became angry

about something. One incident was when Dr. Herbel towards the end of the evaluation began to challenge some of his discrepant statements. As I understand it Mr. Bejaoui became very angry and accused Dr. Herbel of being a number things, throwing insults and profanities his way about being unprofessional and not caring about his patients and so on and so forth. And as Dr. Herbel explained to me, during that exchange he was struck by, again, how organize and together and lucid and clear he was, not confused at all but, again, seemed much more together than other interviews and other times he had met with him during that episode.

Q. In your view is that consistent with Dr. First's theory that the defendant was so terrified by his doctors that he can't even provide his own name?

A. No, I don't think that is consistent with that.

Q. You said there is one other incident.

A. With me actually. On March, I think it was the 8th is when I had my last interview with him after which he refused to speak to me any longer, it was during that incident that or during that interview, excuse me, that I approached him and indicated to him I'd like today for us to talk about your legal situation because that's an important part of why you are here. And to make a long story short he became angry when I tried to have a discussion about the indictment and I mentioned, well, your name's on the indictment. So it's going to be important

that you work with your attorney and try to defend yourself and it's important you understand your rights so the government doesn't railroad you. I was trying to elicit his interest in talking about the case and he got real upset about the indictment. He said he didn't have any federal charges at all. He wasn't aware of that or didn't have any and became very angry. He says I have been railroaded my whole life and made a lot of our comments but more organized, more fluid in his speech than I had ever seen. At other times he was stumbling over his words, drooling, presenting completely different. But during that episode I saw a different side.

Q. Again, consistent with the degree of paranoia that Dr. First explains is his behavior?

A. I don't think so, no.

Q. There's one other incident referred to in your report which involves an occasion after that meeting just described where the defendant begins to refuse medication and then, ultimately, resumes medication. Just explain what happened there.

A. Sorry. What page are you on?

Q. I believe it's 18 and 19 where it is described.

A. What essentially -- yes, after my interview he got upset. He said he was going to refuse his medicine. He may have said that he was going on a hunger strike. He was clearly upset. And there was concern because some of the medicine -- well, in particular, his high blood pressure medicine there's concern

about abruptly discontinuing that medication. Certain medications it's safe to discontinue quickly, others it's not. And he was informed -- let me get it right. He was informed that if he was going to refuse that medicine we needed to have closer observations of him, again, for any kind of risk of medical problems from abrupt discontinuation. And he would have to be moved closer to the nurses' station where he would have a roommate in his room. At the time he was single celled. In fact, I think he had a room to himself through the entirety of his admission. He made it clear he did not want that to happen and subsequently continued resuming with the treatment for the high blood pressure medication, I think one other so as to avoid having a roommate. And he said he wasn't able to -- he was in too much pain to go to pill line I think it was. And when he realized he had to do that he was capable of, again, overcoming that reported problem of pain and went to the pill line on the unit.

Q. Doctor, in your experience if a patient had a legitimate delusion that their medicine was being poisoned by their doctors, would he take the medicine any way in order to avoid having a roommate?

A. If he is legitimately paranoid?

Q. Yes.

A. In my experience, no. Those who are legitimately paranoid they don't take any medicine. They have to be to the point

where we have to force that on them if it's legitimately appropriate to do so.

Q. So what is the defendant's behavior in this set of incidents indicate to you about your diagnose?

A. It strikes me as volitional as another example of when he has -- when there's something that he wants or he has a goal or wants to avoid, he is capable of organizing himself and behaving appropriately.

Q. And how does that inform your diagnosis of malingering?

A. Again, it was another inconsistency. I wouldn't expect that of a extremely paranoid psychotic person or someone who is suffering from the problems that he reports.

Q. You listen to prison calls in the course of making your diagnosis, correct?

A. Yes.

Q. Why do you review prison calls in this type of case?

A. Well, any time there is question about the voracity of someone's claims it's sometimes helpful to review the phone calls. Now, inmates or defendants know that the calls are being monitored but you'd be surprised how sometimes people let down their guard or say things or behave in a certain way that can have useful information. Sometimes it's very consistent with their presentation on the unit and it confirms or disconfirms hypotheses. And other times you find inconsistencies and the you have to figure out why that is. So

that was my purpose of listening to Mr. Bejaoui's calls because it had already been indicated in reports that there was some question of truthfulness in his reports.

Q. Did you review all the calls that he made from Butner when you were preparing your report?

A. No, I typical don't especially if they make numerous phone calls. I try to make a random sample of phone calls. For one, I don't have the time to listen to every phone call if they're hours and hours. Plus too, there's usually a point of administering returns, listen to even eight calls versus 14 calls. Usually in my experience anyway doesn't yield much if anything. Sometimes it could.

Q. In the calls that you reviewed prior to producing your report what, if anything, did you find significant?

A. Well, as Dr. First having testified it was remarkable in terms of the, not the content of his speech. A lot of times I am not such concerned about what they say but how they say it and how they come across. And he came across, it couldn't have been more night and day with how he came across with us versus the family members. That legitimate hypothesis to say maybe he's afraid of us and behaves differently than people he is comfortable with. But just looking at a pure behavioral observation, he was very organized. He did make a periodic statement in which if you take it at face value would be a concern for delusions. But if you take the totality of the

calls he was organized. He remembered information. He communicated, regular dialogue question and answer with his wife. You wouldn't know from the phone calls that he was an impaired individual necessarily except for some smattering of paranoid statements.

Q. Well, Dr. First has two theories that can be broken apart about these calls and you've mostly discussed one already which is the notion that he is comfortable with his wife and friend but terrified of you. Is there anything else that can explain why you don't agree with that theory besides what you talked about a few moments ago?

A. Well, one, I don't think he is terrified of us but be that as it may --

Q. Is anything else that you hadn't already explained to the Court that you'd like to explain why you don't agree with that assessment by Dr. First? I want to make sure I haven't left anything out that you'd like share.

A. If you were to take at face value some of the statements that he made they sound paranoid. However, what struck me is if you listen or review all the calls and I didn't until reading the transcripts.

Q. Let me ask you stop there. I am going to ask you some questions about the paranoid statements in a moment. I'm just focusing now on Dr. First I believe -- and correct me if you have a different impression -- has expressed the view that the

reason that he is fully coherent when talking to his family and friends and completely impaired when talking to you and to the other staff at Butner is because of a paranoid delusion which renders him essentially so scared that he can't function outside of the context?

A. No. I understand.

Q. Why do you disagree?

A. I dispute that because if he was so impaired because of fear with us he wouldn't talk to us at all. He wouldn't participate tot he degree with the procedures, taking the medicine, eating the food and so on. So -- and I have had patients like that who are so incredibly frightened and it is not that they can't remember their names, they won't talk to you. They won't even engage at all. They won't take medicine. They wouldn't do anything if they are that fearful. And even among those who are so fearful you don't see some of the -- such a drastic ability and disability between how they are with you and how they are with people they trust in terms of the cognitive impairment being so grossly impaired. You just don't see that with paranoid people.

Q. Do you paranoid people feign dementia when he interact in evaluations?

A. Legitimately?

Q. Yes.

A. No, not typically. I can't think of a case where they've

feigned dementia.

Q. The way that the defendant did here. Withdrawn. Let me start from block one. The defendant here gave responses to you which indicated serious dementia in your evaluation, right?

A. Again, if you were to accept it at face value that would have been on the forefront of your mind that there's something serious going on, medically, a dementia delirium.

Q. Would it be possible if the defendant or -- withdrawn. Is it consistent with your experience that a legitimately extremely paranoid patient would feign dementia the way the defendant did?

A. No.

Q. I think the second point that Dr. First has made about these calls is as you alluded that there is paranoid or delusional statements within the calls. Do you believe that that indicates that he is actually delusional?

A. It was a consideration. I ultimately concluded no. In the context of everything including the fact that again, what's atypical is that people who are very paranoid, that's all they can talk about. They're consumed with it. They share it with everybody. If people were trying to kill them that's all they talk about on the phone with their family. So, the fact that he had four or five incidents where he would make that paranoid comment and go right back to the regular conversation and in the scheme of things was such a small part of that

communication, if he was so fearful we were trying to kill him and we're trying to harm him, like I have had many patients before in the past, again, they are consumed with. That's all they can talk about. And that wasn't the case. So that struck me but it was a hypothesis I certainly entertained is that oh, maybe there's a consistency here between his self-report and some paranoid statements on the phone but I ruled that out.

Q. Why would someone who was not legitimately suffering from paranoid or from delusions make these type of statements in your experience to friends and family?

A. In order to elicit their cooperation in the ruse of malingering symptoms.

Q. Since completing your report have you reviewed other calls beyond the ones you reviewed at the time?

A. Yes. I've reviewed transcripts after all the calls that you provided several days ago.

Q. Those are just the calls made up until the time the defendant left Butner, correct?

A. I believe so.

Q. Having reviewed those were though generally similar to the calls that you've previously reviewed?

A. Yes. Yes. I mean there were other examples that I hadn't reviewed before, you know a couple paranoid statements and a couple phone calls and a few other things that, again, I did not review the first go round but the general gist was similar,

yes.

Q. I'd like to play a couple calls. First, when did the defendant arrive at Butner?

A. I believe it was January 27. Yes.

Q. Could we play January 29 at 6:16 p.m. which is a transcript is Government Exhibit 7 and it's the call between the defendant and his wife. Are you ready, Dr. Cochrane?

A. Yes. Go ahead.

THE COURT: What page and what line?

MR. WILSON: From the beginning -- to be clear, I am going to play the entire call when it is, the first call that's made to defendant's wife, I believe, from Butner. I apologize. It is the second call. The first is a very brief call that's terminated quickly.

(Audiotape played)

BY MR. WILSON:

Q. So, doctor, that was January 29th. Do you recall how long after that you first interviewed the defendant?

A. Yes. Me personally?

Q. Yes.

A. I believe it was February the 3rd.

Q. About four days?

A. Yeah, sounds right.

Q. Just to be clear, how did his presentation in that interview with you compare to what you just heard on the phone?

A. Well, as I described in the report he is grossly impaired, didn't know where he was located, didn't know his age. I believe he didn't know his first name or how to spell his first name, so on and so forth. So he was severely impaired, not at all as, obviously, is recorded here.

Q. Let me point you to a couple of particular spots. First, on the bottom of page 4 we've already listened to this while you were in court, but just to confirm your understanding the reference to being in North Carolina.

A. At the very bottom, this, yes.

Q. Is that consistent with what you were hearing from him when you were evaluating?

A. No. During my interview he didn't know where he was located, the state or the facility.

Q. And if you turn to page five and look at line 25 through 30, really referring back a little bit but you just heard it. Defendant indicates that he thinks it's been about sevens month since he was moved from New York. And then actually counts them out to include June through January.

MR. DRATEL: Objection. That's not what it says.

MR. WILSON: Withdrawn.

Q. Maybe more or maybe seven if you count from all June, July and August, I don't even remember the months, is what he says. This took place in January, correct?

A. The phone call, yes.

Q. How many months is it between June and January?
A. My calculation it would be seven months.
Q. Is that consistent with what he was telling you in the interviews that he had with you?
A. No. It shows he was fairly oriented at the time.
Q. Now, looking a little bit further up the page at line five to 15 or so, there's a conversation about a meeting with a lawyer, correct?
A. Yes.
Q. What does it indicate to you about his understanding of who his lawyer is and his role?
A. Seems to clearly indicate that he understands what the role of his attorney is. He expresses his frustration and, of course, his desire to be sent back to the New York area. But it, certainly, suggests that he understands his attorney represents him.
Q. And this portion, the last two sentences in which defendant states that the further you are getting me, the more you are getting me not willing to work with him or to talk to him. That is referring to the lawyer?
A. That's my standing, yes.
Q. What does that indicate to you, if anything, about his ability or inability to work with a lawyer?
A. Well, he is stating that he might not be willing do so.
Q. And that would not be an inability to do so, correct?

A. No, not necessarily. I mean, I suppose you could be unable and say that you are not unwilling but it seems to suggest that he understands what willing to cooperate means and he is saying he might not.

Q. Now, go back to page two please and starting at line 31, want to look down there and through to the next page, page eight. Excuse me. Page three, line eight. Do you draw any conclusions from that about what type of information Maria Bejaoui was providing to counsel?

A. I am sorry.

Q. Well, sorry. Let me break it down more. The first line here is Mondher at line 31 of page two you know what they did to me, Maria? They moved me to another place. You know I am not over there any more. Maria says, I know. I know. You know I get your mail I called them. What do you understand that to mean?

A. I understand that to mean that when she gets correspondence from him she contacts the attorney.

Q. And then if you go to page three, line one Maria says, you know, but I am letting them know I haven't heard from you, you understand. I put it in that form because I want them to understand that you are not capable of writing.

Do you draw any conclusions about the reliability of Maria Bejaoui's statements from what I just read here?

MR. DRATEL: Objection, your Honor, as to form.

THE COURT: Rephrase it.

BY MR. WILSON:

Q. Doctor, in evaluating the information you received from Maria Bejaoui in making your evaluation, does what I just read to you have any relevance to the weight that you give it?

A. Well, does this statement have weight to her credibility?

THE COURT: Are you inclined to believe the truthfulness of what she told you more or less after having read this?

THE WITNESS: I'd be inclined to say less, your Honor.

MR. WILSON: I'd now like to play a series of clips from calls between the defendant and his wife taking place between February 9, 2012 and February 13, 2012, some of which we've seen a little bit of in the past. That's going to be transcripts, will be grand jury -- Withdrawn. The first will be Government Exhibit 11 will be the transcript that February 9 to the 12th at 7:48 p.m. I need you to listen to all of these in sequence and I am going to ask you some questions about them considering the whole chain of conversations.

THE WITNESS: I don't have Government Exhibit 11 or if I do it's out of order.

THE COURT: Are we doing 11 and 12?

MR. WILSON: 11 and 12 and 13.

THE WITNESS: I have 13. I do not have 11 or 12.

MR. WILSON: Hold on one moment and we'll get you

those copies.

(Pause)

MR. WILSON: If we could have the February 9th call.

(Audiotape played)

MR. WILSON: Next we're going to February 10 at 5 p.m. 2012, goes to about the end of page three and that's Government Exhibit 12.

(Audiotape played)

MR. WILSON: And last we could do a call on --

MR. DRATEL: Could we just have the next line.

MR. WILSON: I can read it aloud if that works for the judge. Maria says, right. And then Mr. Bejaoui says, I am sure they want to kill me, Maria. I'm telling you they are not treating my pain they just want to -- God knows what they want.

We can do the rest of the call if you'd like.

MR. DRATEL: This is fine.

MR. WILSON: We can do Exhibit 13 transcript and that's a call on February 13, 2012 at 1:29 p.m. again, this is defendant and his wife.

(Audiotape played)

BY MR. WILSON:

Q. Doctor, in that first call Mrs.~Bejaoui states that a doctor called her from Butner.

A. Yes.

Q. And then in the next two calls there's some considerable

discussion by Mr. Bejaoui about a man and al lady and we heard some of that earlier today with Dr. First, correct?

A. Yes.

Q. And Dr. First stated that he thought that that was sort of incoherent and delusional statements?

MR. DRATEL: Objection, your Honor.

MR. WILSON: Withdrawn.

MR. DRATEL: Objection to characterization. Previously said the first call. You are talking about the first call you just played. There is nothing about a doctor in that, right?

MR. WILSON: Fair enough. On line 15 of Government Exhibit 11 Maria says, all right. The doctor or psychologist called me from there.

Q. Where do you understand "there" to be in the context of this call?

A. I believe she was referring to us the doctors at Butner.

MR. DRATEL: Where? What page are you on?

MR. WILSON: Government Exhibit 11, page two, line 15. The first one we played is Government Exhibit 11 on February 9.

BY MR. WILSON:

Q. Do you recall Dr. First's testimony about the lady and the man in that portion of the call that was played?

A. Yes, I do.

Q. In your own words, what would you say that his explanation

for that was?

THE COURT: His explanation for what?

MR. WILSON: What it indicated about the defendant's mental state.

THE WITNESS: I don't want to mischaracterize but my general recollection is that he wasn't certain what the man and lady that was being referred to who that is and that it seemed to suggest confusion or possible paranoia.

Q. Is that your interpretation?

A. No, it's not.

Q. What is your interpretation?

A. My interpretation in looking at all three of the phone calls put together is that Mr. Bejaoui was coaching his wife as to what to say and stressing to her in a coded covert way about how the letters he'd been writing her are weird. He's been talking about killing you all the time and instructing her on how to inform the doctors.

Q. I want to point you to Government Exhibit 12, in particular on page two, line 21 which is the first reference I believe to the lady when she gets the phone call.

A. Yes.

Q. If you then go down there's a series of back and forth on line 36. We ultimately get to Maria, yeah, the people that's supposed to call me.

A. Yes.

Q. And that one of the elements of this call that indicates to you that that's what is going on here?
A. That's one of the elements, yes.
Q. I won't go through the others. Are there other instances where Mr. and Mrs.~Bejaoui switch back and forth between the lady and the man and personal pronouns referring to themselves?
A. Yes, there are.
Q. Now, let me point you in particular on page three of that document.
THE COURT: Is that consistent with the sense of paranoia on his part that he doesn't want anyone to know who the lady and the man are?
THE WITNESS: No, I would not find that consistent with general paranoia.
THE COURT: Why.
THE WITNESS: Because someone who is paranoid I don't believe they would have need to tell their wife to communicate their paranoia and their fear and their strange writings to evaluators. I've never experienced that.
Q. Speaking of the strange writing, point you to page three and line nine and ten, what is Mr. Bejaoui saying there?
A. Starting on page, or excuse me on line nine?
Q. Yes.
A. He says, letters you don't understand any more, writing the letters, the handwriting is different.

Q. And then if you look down to line 26, the full sentence there, what does that state?
A. You know and then his letters are very, um, his letters are weird, the talking is very weird. There's big changes, you know, so much being away, you know things of that nature.
Q. Now, you reviewed Dr. Channel's report from Devens?
A. Yes, I did.
Q. Do you have a copy in front of you?
A. Give me a moment.
Q. That would be Defense Exhibit C, I believe. If you look on page 4 of that report down to the third paragraph or the second full paragraph.
A. Page four.
Q. Yes.
A. Okay.
Q. And if you go down to the third line from the bottom there there's a sentence that begins "since that time".
A. Yes.
Q. Just read that.
A. Since that time she has not visited him but has corresponded with him through letters. She reported she "can't understand the letters sent by her husband describing them as, quote, like and that at least something a little kid would write, unquote.
Q. Are there any other references in the course of the calls

you've reviewed to letters being received by Ms. Bejaoui?
A. Sorry. I have is there other --
Q. Is other correspondence referenced in the calls?
A. Yes, I do recall. I don't remember precisely which calls but there was reference to sending and receiving letters between the two of them, yes.
Q. And at any time does Ms. Bejaoui in those indicated that she doesn't understand something that her husband wrote to her?
A. Well, during the phone call with Dr. Herbel when he interviewed her she did not, nor did she contact us subsequently or any of the remainder of time he was with us to report that.
Q. In the calls there is discussion about letters that she received from him, correct?
A. In the recorded phone calls, yes.
Q. Aside -- withdrawn.

In any of those calls does she suggest that she doesn't understand the contents of the letter she receives?
A. No. Actually, her response seems to suggest she understood what he was requesting. She was going to fax things on. There was nothing in there that suggested, hey, what are you talking about? I don't understand letters. What are you trying to say? There was nothing like that.
Q. Going back to page three of Government Exhibit 12. Right after where we were looking at before, an outline 14 there's a

series of statements by Mr. Bejaoui.

A. Page three, what line?

Q. Says the thing he didn't want to speak about on Rikers Island because it must be very hard for him because he doesn't want to disclose and makes him cry and stuff like that. And what else have you noticed? I mean what else she have noticed, paranoid always talking about killing and stuff like that and afraid, you know because the things they have done this him.

THE COURT: What's your question?

Q. What significance do you attribute to that in making your diagnosis?

A. In the context, again, of each of those that you've shown me I think that buttresses the argument that he's malingering psychiatric symptom.

THE COURT: That coaching, right?

THE WITNESS: That's the conclusion I draw, your Honor.

THE COURT: All right. Let's go off the record.

(Discussion held)

THE COURT: Let's pick it up tomorrow. Did you want to conclude?

BY MR. WILSON:

Q. Mr. Dratel asked me to read to portion of that transcript we were just looking at which is slightly farther down. Just give me one moment to find it again. Line 32, Mr. Bejaoui just

after that statement about -- to his wife about suggesting that always talking about killing and stuff like that he then says, I am sure they want to kill me, Marie. I am telling you they are not treating my pain. They just want to diagnose what they want. In light of the rest of the call how would you interpret that statement?

A. Again, in the context of the call I would be highly suspect. In fact, I don't give it much weight that that is an actual paranoid statement.

Q. Would you expect to see someone coach a loved one to say that they're paranoid and then immediately fall into a paranoid delusion?

MR. DRATEL: Objection.

THE COURT: Yes, sustained. Leading.

Q. In your experience treating paranoid individuals, would this sort of coaching be considered unusual?

MR. DRATEL: Objection.

THE COURT: Sustained.

MR. WILSON: I apologize, your Honor.

Q. Have you seen this type of behavior from seriously paranoid patients that you've treated?

A. No, I've not.

MR. WILSON: I think that's a good stopping point.

THE COURT: All right. We'll pick it up again at ten tomorrow.

(Adjourned to Tuesday, August 14, 2012 at ten a.m.)

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